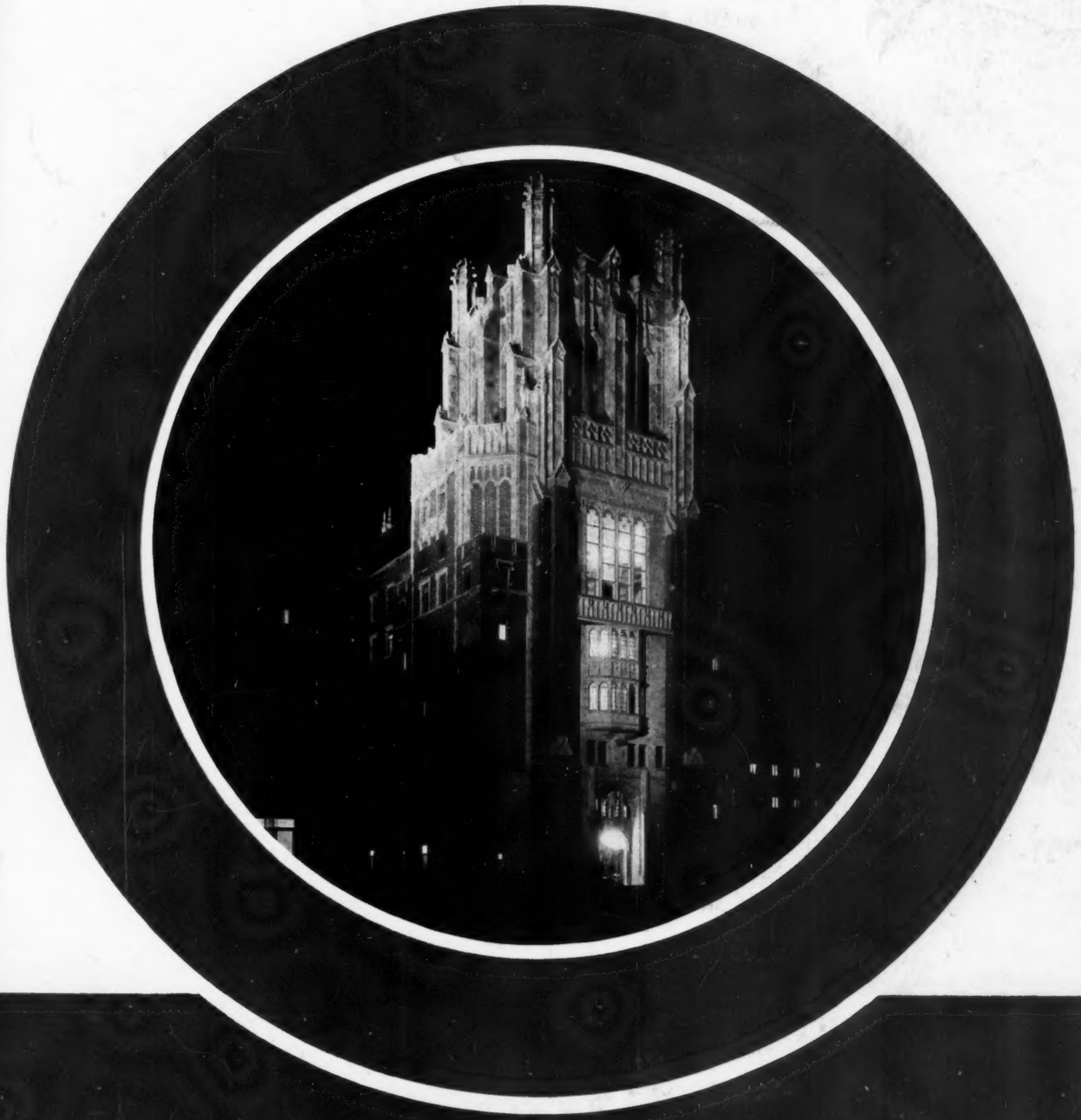


the MODERN HOSPITAL

VOLUME 46 FEBRUARY 1936 NUMBER 2

Fifty-Three Years of Continuous Service To Those Who Feed Many People Each Day

FIFTY-THREE YEARS YOUNG—unencumbered by outworn traditions—the Sexton organization is continuously alert to develop new features for your benefit and convenience. At the same time, every care is taken to maintain the traditional features that have made dealing with Sexton most pleasant and profitable. Canned tuna is just one example. In 1883 it was unknown, as were many other varieties of canned fish which are now packed under the Edelweiss label. Always, as each new variety of sea food was added to the Edelweiss line—Salmon, Shrimp, Crabmeat, Sardine—the most exacting care was used in selecting the type best suited to your needs. You will be delighted with Edelweiss canned fish.

Sexton Specials offer outstanding values in foods prepared exclusively for those who feed many people each day.

JOHN SEXTON & CO.

CHICAGO — BROOKLYN

Manufacturing Wholesale Grocers

Established 1883

America's Largest Distributors of No. 10 Canned Foods

CONTENTS

For February, 1936

Just in Passing—

KEEPING the calendar straight is no easy task for a magazine editor. His thoughts must constantly be far ahead of those engaged in other activities. While his neighbors are talking about the cold of January he must be thinking of the warmth of spring and the heat of summer. When they speak of the balminess of April he must think of the housekeeping and dietetic problems of the fall. Thus he is always living in two different periods. He can usually tell you the day of the month easier than he can the month of the year.

So while you have been speculating about the depth of the snow or wistfully eyeing the diminishing coal pile, your editors have been thinking of the new nurses' home that you will be building this spring, and the air conditioning equipment you will be putting into the operating suite. In other words, the March issue is rapidly taking shape. As usual it will be devoted to the planning and equipping of hospitals and to their maintenance.

Few issues of The MODERN HOSPITAL have been as much in demand as the one published last March. From architects, hospital superintendents and interested public citizens all over the country have come requests for copies. The supply was exhausted long ago. One of the most popular features of that number, the portfolio of floor plans of small general hospitals, is to be repeated this year in revised and somewhat extended form. Only general hospitals of fifty beds or less were admitted to the portfolio last year. This year a few slightly larger hospitals will be admitted.

Published the first of each month by

THE MODERN HOSPITAL PUBLISHING CO., Inc.

Charter member Audit Bureau of Circulations

919 NORTH MICHIGAN, CHICAGO—Telephone, Superior 6402

NEW YORK OFFICE—101 Park Avenue. Telephone, Ashland 4-2445

SUBSCRIPTION—United States and Possessions, and Canada, $3.00. Foreign, $4.00.

Single copies (current), 35 cents. Back copies, 50 cents to $1.00.

Entered as second-class matter, Oct. 1, 1918, at the Post Office at Chicago, Ill., under the act of March 3, 1879.

Printed in U. S. A.

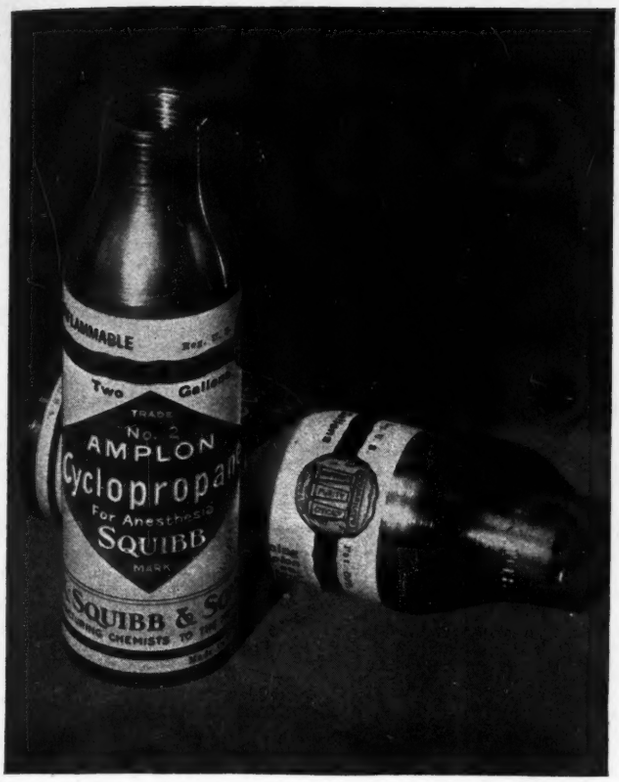
CONTENTS

IN addition to the portfolio of plans, the March number will contain two descriptions of air conditioning installations. Hospitals must reckon with air conditioning. Theaters, restaurants, hotels, department stores and office buildings are teaching the public to expect respite from summer heat and humidity in public buildings. Hospitals here and there are trying air conditioning, cautiously at first until they learn its cost and the public's reaction to it. The results so far observable appear to indicate that air conditioning is distinctly beneficial to most types of hospital patients and that in the warmer climates at least it has a pronounced public appeal. Next month two hospitals that are pioneering in this field will report their experiences.

MOST of the March issue will be devoted to comprehensive and authoritative discussions of particular aspects of the general problem of construction and modernization. Among the subjects that are scheduled for consideration are the hospital intercommunication system, the architectural problems of the hospital laundry, preventing fires in hospitals through careful construction, the third and concluding installment in the series on plumbing hazards and the planning of hospital kitchens.

THE small hospital can and should achieve a standard of performance that will win the approval of the national standardizing agencies. Nevertheless these agencies must give reasonable consideration to the special handicaps under which the smaller institutions must labor. Next month Dr. W. S. Rankin, whose knowledge of small hospital problems is both broad and deep, will discuss this issue. Few men in the United States are better qualified to do so.

THE warfare on our enemies of the insect realm is being carried into the enemy's camp. This month Mr. Laferriere points out the Achilles heel of every bedbug. Next month it will be the turn of the house ant. Readers are invited to



A vest pocket container for a new anesthetic gas

CYCLOPROPANE SQUIBB, a new anesthetic gas, is supplied in a distinctly new type container—the Amplon*—which provides the great advantages of convenience, economy and safety. The No. 2 Amplon (which holds 2 gallons of the gas—sufficient for from one to three anesthesias) is so small and light that it can easily be carried in the vest pocket.

After many years of investigation by competent anesthetists, it has been definitely demonstrated that Cyclopropane is a valuable anesthetic agent. It produces a degree of relaxation comparable to that of ether. Induction and recovery are more rapid, and it has no untoward effects on mucous membranes, lung tissue, liver or kidneys. It is the only gas used alone which has sufficient potency to produce adequate relaxation for major operations.

NOTE: Induction of anesthesia with Cyclopropane should be attempted only by those trained in its use. The carbon dioxide absorption technique is the method generally employed. This involves the use of a gas machine equipped with an absorber and a device for accurately measuring the flow of gases. The anesthetist must, of course, be familiar with rebreathing and absorption technique.

For literature and further information address Anesthetic Department, 745 Fifth Ave., New York

E·R·SQUIBB & SONS, NEW YORK
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

*Registered U. S. Pat. Off.

submit any questions they may have regarding insect extermination. Mr. Laferriere has agreed to provide answers. Inquiries may be addressed to The MODERN HOSPITAL.

A NEW feature in the magazine is the series of thumbnail articles by members of the editorial board. These will be found scattered through the book. They represent the thoughts of hospital leaders on some of the minor but often worrisome aspects of hospital administration. During the course of the year various members of the editorial board will contribute.

FLASHES FROM THIS ISSUE:

"It seems to me that the small training school is being unfairly blamed for the abundance of poor material on the market." *Page 49.*

"I believe it is an unfortunate thing that our voluntary hospitals have become popularly known as 'private.'" *Page 41.*

"The character of the personnel, important as it is in every type of organization, plays a particularly major part in the success of hospital work." *Page 45.*

"It is not primarily because of facilities or equipment that government hospitals are criticized but rather because of personal factors." *Page 62.*

"Whether we approve or disapprove the principle of health insurance, we must face the definite consideration that the public is demanding some such legislation today." *Page 65.*

"The inspection of storage boxes as to sanitation and cooling should be of vital interest to the executive's group." *Page 81.*

"The destructive attitude of undertakers which results in the loss of autopsy permissions is an interesting problem which can be solved only by education or by pressure brought by the hospital executive upon these persons." *Page 81.*

"Irradiated foods and pharmaceuticals are effective antirachitics." *P.100.*

"The lowering of the death rate of which we are so justly proud has been achieved largely by the conquest of the diseases of early childhood." *Page 78.*

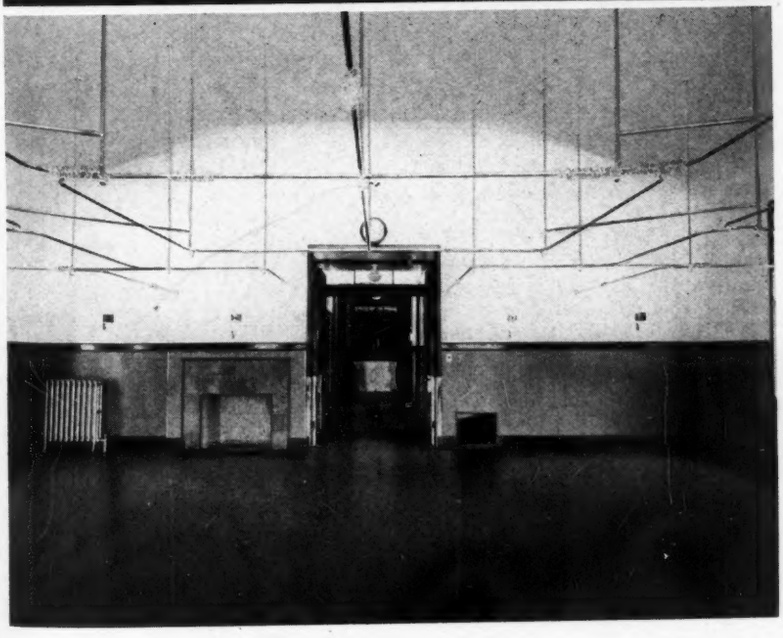
"We do know that a properly maintained school is more expensive to a small hospital than a graduate service." *Page 49.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
OTHO F. BALL, M.D., *President*
919 NORTH MICHIGAN, CHICAGO, ILLINOIS

JOSEPH C. DOANE, M.D., *Editor*
RAYMOND P. SLOAN, *Associate Editor*
ALDEN B. MILLS, *Managing Editor*
JANET PETERKIN, *Associate Managing Editor*

Wentworth Hospital performs simple operation in modernization with SEALEX floors and walls



Note the handsome, modern effect produced with Sealex Floors and Walls in the reception room and ward of Wentworth Hospital, Dover, N. H.

Wentworth Hospital, Dover, N. H., believes hospital interiors should be as up-to-date as the laboratory and operating equipment. That's why modern Sealex Linoleum Floors and Sealex Wall-Covering were selected to help make its rooms sanitary, attractive and cheerful.

Sealex materials are in use in hospitals all over the country today. They are highly sanitary, durable and inexpensive to maintain — meeting every practical requirement.

Sealex Linoleum Floors are quickly installed without costly preparatory work. They are comfortable and quiet underfoot—more restful to patients and less tiring to the hospital staff. Easy to keep clean and never cost a cent for scraping, painting or varnishing.

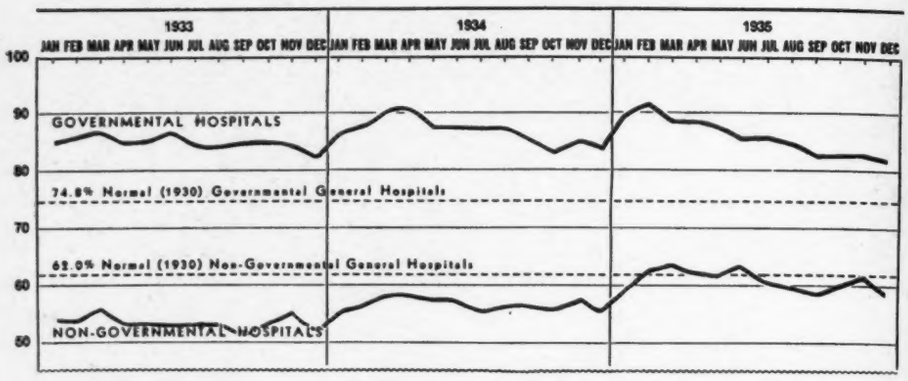
Sealex Wall-Covering, too, is easily applied right over the old walls. A Sealex Wall has an easily washable surface that is impervious to the entrance of dirt and germs. It lasts a building's lifetime without refinishing expense.

In new construction or remodelling projects, Sealex materials are expertly and economically installed by authorized contractors of Bonded Floors and Walls. Such installations are backed by Guaranty Bonds covering the full value of workmanship and materials. Write us for full information on Sealex Floors and Walls.

CONGOLEUM-NAIRN INC.
KEARNY, N. J.

SEALEX TRADEMARK REGISTERED *Linoleum Floors and Wall-Covering*

The Hospital Barometer



As is customary over the Christmas holidays, there was a drop in the occupancy of voluntary and government general hospitals in December, more marked in the former than the latter group. The occupancy in the voluntary hospitals (58.8) was, however, higher than in December, 1934 (56.3) or December, 1933 (52.6). In the government hospitals the trend is now the other way, the figures for the three years being, in the same order, 81.6, 83.9 and 82.1. Corrected figures for the government hospitals show that the decline in the overcrowded condition of these institutions is continuing.

Thirty new hospital building projects were reported in the period from January 1 to January 27. Of these twenty-nine reported costs totaling $8,137,330. There was one $13,000-alteration, one $50,000-nurses' home, four new hospitals to cost $296,000 and 24 additions of which 23 reported costs totaling $7,778,330.

A special compilation by the information department of The MODERN HOSPITAL reveals that, on January 25, there were 429 active hospital building projects known to the department and they involved a total estimated expenditure of $103,385,752. Of these 285 are additions to existing hospitals (including new buildings on the same grounds), 22 are nurses' homes, 110 are new hospitals and 12 are alterations of existing buildings. Seventy-five of the active projects are being planned, bids are being taken on 70, contracts have been let for 129 and work is actually under way on 155 jobs.

In addition to these active projects there are 493 contemplated projects which are estimated to cost $85,808,347. Of the contemplated projects, 13 are nurses' homes to cost $1,035,000, 162 are new hospital buildings with an estimated investment of $31,458,459, 272 are additions to involve $51,573,837 and 46 are alterations on which it is expected that $1,741,051 will be spent.

The total for both active and contemplated projects is nearly $190,000,000.

World industrial production increased in December for the fourth consecutive month, according to the National Industrial Conference Board. The general wholesale price index of the *New York Journal of Commerce* rose in the last week of December from 80.2 to 81.3 and then fell. For the week ending January 20 it stood at 78.9 (1927-29=100). During the period from December 23 to January 20 grain prices rose from 81.8 to 84.4, general food prices, on the other hand, dropped from 80.3 to 75.2, textiles dropped slightly from 67.6 to 66.0, fuel advanced from 80.8 to 82.0 and building materials remained practically stationary at 90.9. The price index of drugs and fine chemicals compiled by the *Oil, Paint and Drug Reporter* advanced slightly between December 30 and January 20, going from 184.1 to 185.5 (August, 1914=100).

OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

Type and Place	Census Data on Reporting Hospitals[1]		1934	1935										
	Hospitals	Beds[2]	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Nongovernmental															
New York City[3]	68	15,194	66.0	70.0	72.0	74.0	70.0	75.0	72.0	66.0	62.0	62.0	67.0	67.0*	67.0*
New Jersey	58	9,772	58.0	62.0	65.0	66.0	65.0	66.0	64.0	62.0	60.0	60.0	62.0	62.0*	62.0*
Washington, D. C.	9	1,790	61.8	72.0	71.8	70.5	69.8	68.7	70.6	68.2	62.0	63.9*	63.9*	68.3	63.0
N. and S. Carolina	102	5,950	56.8	60.6	63.1	64.9	62.3	64.6	66.8	65.7	66.3	65.7	64.4	63.3	59.1
New Orleans	7	1,146	44.9	47.7	49.5	50.1	46.8	50.9	58.3	57.1	58.2	55.1	53.3	55.8	50.8
San Francisco	16	3,081	62.0	65.5	68.2	67.4	69.5	66.4	67.4	62.4	63.9	63.9	66.7	70.2	65.4
St. Paul	7	848	45.8	41.5	53.6	55.9	52.3	48.8	51.7	46.4	49.1	48.5	46.6	50.7	49.0
Chicago	24	6,190	54.5	57.4	57.3	61.9	58.8	55.9	54.7	54.5	53.8	53.6	54.7	54.9	53.3
Cleveland	8	1,567	56.5	61.9	62.0	62.0	63.6	65.7	63.4	63.2	63.4	58.5	61.7	62.3	59.3
Total[4]	299	45,538	56.3	59.8	62.5	63.6	62.1	62.4	63.2	60.6	59.9	59.0*	60.0*	61.6*	58.8*
Governmental															
New York City	17	12,317	92.9	96.7	100.6	103.2	104.6	105.6	100.4	103.6	93.2	91.7	85.8	86.5	87.3
New Jersey	6	2,122	78.0	86.0	86.0	84.0	85.0	84.0	77.0	79.0	79.0	76.0	84.0	84.0*	84.0*
Washington, D. C.	2	1,596	77.6	86.6	95.5	76.3	72.7	69.4	67.4	68.4	69.5	62.9	62.9*	60.4	62.9
N. and S. Carolina	13	1,256	64.7	65.4	65.7	68.5	65.8	68.6	68.1	68.7	72.3	68.0	66.9	65.4	63.8
New Orleans	2	2,227	130.5	144.9	145.4	130.4	130.8	132.8	138.8	149.0	143.1	140.9	138.5	137.4	127.8
San Francisco	3	2,255	74.2	77.4	79.1	77.1	80.3	77.3	72.3	72.0	71.3	79.5	76.8	79.1	81.1
St. Paul	1	1,000	68.8	74.4	78.7	77.8	75.8	75.2	74.5	67.3	63.4	61.5	65.0	68.6	66.6
Chicago	2	3,880	84.7	89.0	83.4	93.9	84.2	86.0	84.5	83.5	80.5	80.4	81.7	80.2	79.5
Total[4]	46	26,653	83.9	90.1	91.8	88.9	88.7	87.4	85.4	86.4	84.0	82.6	82.7*	82.7*	81.6*

[1]Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. [2]Including bassinets, in most instances. [3]Includes only general hospitals. [4]The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

The Editor Talks It Over

• February, the Roman month of purification, once the last of the year is now the period of presidential birthday holidays. Besides its leap year possibilities it offers to dietitians splendid opportunities for the decoration of her menus with hatchets, rail fences and cherry trees.

The birth year of the first president also marked the birth of the first almshouse and infirmary in the United States. Twenty years later the first chartered hospital was organized. When the sixteenth president was born, the nineteenth century was just beginning. But a half decade before Lincoln's birth, the first locomotive turned its wheels in Wales, and morphine was isolated by a German apothecary. Two years before this event, Fulton's steamboat churned the waters of the Hudson and the oldest pharmaceutical journal in the world was published in Paris.

Holidays of this type not only furnish a stimulus for recalling interesting national and international historic events but also to those who spend their lives within hospital walls they bring an opportunity of exerting an unusual effort, in the course of their observance, to supply to the sick a unique type of cheer and encouragement.

• Would it not be a good idea to have a "Kindness to Machinery Day" in every hospital and devote it to demonstrations as to how machinery and equipment should be used and cared for, discussions of original cost and what losses result from improper usage and neglect? Machines represent many human brains. They are the statues to those who have tried to free man from the bondage of physical labor. They are the instruments that make men live longer, more usefully and more completely. Why not treat them with the kindness which any good servant merits?

• Hospital windows at night tell interesting stories. Blazing hospital rooms on top floors suggest that within white clad figures bend over operating tables in the relief of physical disease. One sees less today of dormer type glass roofs of operating rooms. It took long to learn that they always leak and, aside from providing work for the porters, render no useful service. The North Star no longer attracts operating rooms. Time was when it was as bad form to face the operating room east, west or south as it was to wear russet shoes with evening dress. Today, operators prefer electric illumination to the much advertised cold blue light of the north.

Sparkling windows on private floors indicate the degree of occupancy of private suites. One may even learn s o m e t h i n g concerning economical practices while observing excessive and unnecessary nightly illumination of the hospital and its grounds.

• If in brevity there is wit, the cryptic chart orders and the alphabetical conversation of doctors and nurses must appear amusing to the patient. P.R.N., T.I.D., A.C., P.C., B.N., P.I.D., CA., SA., ad infinitum—are abbreviations commonly used in the daily work of the hospital.

A knowledge of Latin easily explains the derivation and application of these letters. A P.R.N. nurse is one who goes wherever she is needed and an order succeeded by these letters is one given whenever the occasion demands, (pro re nata). Medicines are given either before or after food, (ante cibum or post cibum) or three times a day or twice a night, (T.I.D. or B.N.) in frequency. When the nature of a dreaded ailment is to be concealed, cancer is CA., sarcoma is SA., pelvic inflammatory disease is P.I.D.

Such is the peculiar dialect of the hospital. Every calling from wireless telegraphy to railroading has its own.

• Dr. John Brooks Wheeler remarks in his recent book, "Memoirs of a Small-Town Surgeon," that one of the practices of interns of his day at the Massachusetts General Hospital was to carry ligatures in their buttonhole to be ready for an emergency. The chief surgeon in 1875 wore an old blue long tailed broadcloth coat when operating. Doctor Wheeler remembers this surgeon announcing to a class, "We do not wear gowns here. It is not necessary to look like a butcher to be a surgeon." Then the phenol spray was the favorite antiseptic because germs were thought to be wholly airborne. What virtue do the rainbow hues of antiseptics of today possess? There surely can be no mistake as to the area of skin painted when they are employed. Many still believe the adage, *Similia similibus curantur*, (like is cured by like). A red flannel shirt or a cranberry poultice to many surely prevents the red erysipelas. The practices of yesterday are no more bizarre than some of those of today.

•Few may remember that Dr. John Hall was the son-in-law of Shakespeare and still fewer will recall that this year is the three hundredth anniversary of his death, an event which will be celebrated in famed Stratford-on-Avon. A most interesting sidelight on the activities of this stalwart Puritan—this individualist who first scorned local honor as the burgess of his town and who later was dismissed from governmental councils because of the display of a strong individualistic spirit, will be gleaned from the records of his patients and the utensils employed in their treatment which will be there exhibited. The type of medicine practiced by Dr. Hall bears little resemblance to those of today's modern hospital, either in the nomenclature of the diagnoses or in the curative agents and procedures that are used.

• It is said that too much kindness of a verbal sort kills as surely as do more potent pharmaceuticals. Honeyed words too oft repeated cloy like an excess of candy. The stereotyped "You are better today, Mrs. Jones" may impress at first but fails to be convincing as a steady diet each morning in the week. Private room manners for staff men, interns and nurses should not fail to include a modicum of the psychology of the sick.

• The protruding stethoscope often characterizes the physician and its absence frequently denominates the surgeon. One might wonder whether the ears of the surgeon are so acute that no mechanical aids are needed to detect murmurs, rales and other unusual and interesting sounds. The famous French physician René Läennec who devised the stethoscope knew nothing of earpieces, diaphragms and rubber tubes. His stethoscope was a roll of paper or a spindle of wood. It is suspected that the surgeon would do well to employ the stethoscope oftener and perhaps the internist might emulate the surgeon in practicing his palpation methods.

Looking Forward

Costly Pride

ECONOMISTS have charged that a false pride on the part of hospital trustees costs the nation millions in money annually—that hospitals spring up without either a proof of their need or an assurance of monies for their future support.

Before sweeping denials are made, the hospital field might well pause to consider the methods employed to determine the need for a new hospital. Often, one observes communities in which several struggling undernourished institutions are endeavoring to render medical service where one strong, well equipped hospital would be adequate.

How may one decide whether to start or continue a hospital? Certainly not on the opinion of any one self-centered or self-seeking group or guild. Not even on that of a handful of physicians. Nor is it always wise to fulfill the sentimental whim that a hospital be built expressed in the will of a generous citizen.

Fortunately, the need for the construction of a community hospital can be approached from a much more scientific angle than any of these. Population statistics, proximity to other institutions, methods of transportation available and the occupation of citizens are all factors which, when carefully considered, will prevent many of the gross institutional mistakes which are so evident today. Even the number of beds required for medical, surgical and maternity patients as well as for children, the aged and the tuberculous can be rather accurately estimated.

But today the problem does not so often concern the need for new construction. It centers about a sensible utilization of hospital plants now in existence. We may well ask how the duplication of complicated and expensive hospital equipment can be justified in any community. Why, in an inland city with half a dozen or more hospitals, is it necessary for there to be in operation an equal number of expensive laundries, x-ray plants and ambulance services, while there are no beds for the care of the aged, the convalescent and the tuberculous?

Is there any reason to explain the continuance of the hospital with small bed capacity or of low occupancy in which the cost per patient is inordinately high because of the fewness of those served? To be sure, of the 6,334 hospitals surveyed in the last hospital number of the *Journal of the American Medical Association* 72 per cent were under one hundred beds in capacity and 37 per cent under fifty. The burden of hospital service in this country rests in the hands of its smaller institutions. But the efficiency of the hospital cannot be measured by its numerical bed possibilities. The service which it renders depends on factors far more complicated and expensive.

Seasoned students of the subject believe that the future will disclose a strong trend toward the persistence of large, well endowed, efficiently staffed institutions and the disappearance of the financially and medically weak. Moreover, this is not said to disparage the splendid service rendered by the small hospital. A careful study of many urban communities will disclose financially weak institutions struggling for their very life in close proximity to others of the same size rendering a higher grade of service because of better endowment support. The use of the stronger as base hospitals and of the weaker as special hospitals for the care of the aged, the convalescent, the tuberculous, children or for other special purposes would seem a highly economical and efficient plan.

Amalgamation is the apparently simple solution and yet practically the most difficult. The almost insurpassable barrier of provincial pride and of a demand for full autonomy still remains. Combinations may be of several types, ranging from a complete merger of funds and properties with or without a corporate merger to an administrative combination without any physical change or new construction. Any of these plans may prove efficient.

The lay public offers a challenge to the hospital field when it demands the reason for the expenditure of its money in the reduplication of effort and plant, thus lessening the efficiency of community service as a whole. The public's

dollar must purchase both the highest quality of service and the greatest number of hospital days. Until those directing the hospital are willing without reservation to play their part in a broad community health program this institution will continue to stand out as an example of inexcusable economic inefficiency.

Square Holes and Round Pegs

IS THE present yardstick used in determining the qualifications of interns adequate? The graduates of class A medical colleges routinely possess such knowledge of medicine as enables them to perform under supervision the work of the hospital intern. Rarely do they fail through any lack of formal education.

Many hospital boards, however, are very properly seeking some way of selecting young physicians whose personalities and cultural backgrounds will meet their particular needs. Resentment of discipline, lack of graciousness, low moral tone, selfishness, or absence of any other of those character traits which distinguish the medical gentleman of the present and past, will cause the most brilliant medical student to fail as a hospital intern.

On the clinical side, too, the intern must be chosen to fit the situation. Where close supervision is assured, it is possible to use a man possessing less medical judgment than in the large general hospital where staff visits are infrequent and where a great number of patients are treated.

One fact is unassailable. Round pegs never have been known to fit into square holes. Similarly, those of uncertain cultural, intellectual and moral attributes can never metamorphose within a few months into cooperative, kind and efficient interns.

Saving Dollars, Safeguarding Lives

WITHIN general limitations, each hospital determines its own premium rate for fire insurance. The type of construction, the hazards that exist and the care devoted to minimize hazards and maintain equipment are the principal factors involved.

To a smaller extent but still significantly the experience of each hospital is reflected in the rates charged to all other hospitals. This is clearly shown by the recent reduction by the stock companies in premium rates on hospital buildings in most of the states in the Middle Western area. Last fall the rating organizations in some fifteen Middle Western states made a change in their rating methods which produces a substantial reduction in those risks where fire hazards have been properly controlled, in some instances these reductions being as great as 25 per cent.

The new lower rates in most cases apply to renewals and do not affect policies now in force. However, it would be well for hospital administrators to discuss this feature with their local agents, as in some instances it might be desirable to cancel existing contracts and write policies at the new rate.

In 1924 and 1925 The MODERN HOSPITAL published a series of articles on fire prevention. In connection with this series, arrangements were made with the engineering departments of the leading fire insurance companies, acting through the rating and inspection bureaus having jurisdiction, to provide inspection service to any hospital requesting it. A great many hospitals took advantage of this free service and, when they carried out the suggestions, not only reduced their expenses for fire insurance premiums but also gave better protection to the helpless patients intrusted to their care. Beginning in an early issue, The MODERN HOSPITAL will run another short series of articles covering all important aspects of hospital fire prevention and control. If hospitals will heed the recommendations presented, premium rates can be still further reduced and lives more surely safeguarded.

Does Government Control Follow Government Funds?

THERE has been widespread demand from voluntary hospitals for payment from government funds for their care of indigent persons who are legal public charges. Recent action announced by the board of trustees of the American Hospital Association directs the attention of state and local hospital bodies to the fact that a substantial number of cities and counties throughout the country have for some years been accustomed to pay local voluntary hospitals for services rendered the poor of the locality; a very few states have adopted a similar policy.

It's an old saying that he who pays the piper calls the tune. Can hospitals expect to receive any substantial amount of tax funds without accepting certain responsibilities to the government which appropriates these funds? All would

agree that sound government practice and economy of taxpayers' money require that reports of work done and of finances must be rendered by the institutions that receive government payments. But, hospitals will ask, will a more extended use of government funds mean vexatious interference by government officials in the management of voluntary hospitals? Will it mean control by political authorities over voluntary institutions?

Whatever our ideas may be, it may be well to postpone expressing them until we have considered experience as well as opinions. The recent cooperative study of the council of the American Hospital Association and the bureau of medical economics of the American Medical Association showed that many hundred local governments have been granting tax funds to hospitals for the care of the indigent in the last few years. The hospitals in these numerous cities and counties have something more than opinions to offer. They have experience. The MODERN HOSPITAL does not object to receiving opinions on the general question suggested by the title of this editorial, but it would like still more to receive letters containing the experience of hospital administrators who live in cities, counties or states from which they have been accustomed to receive tax funds for the care of certain sick persons. Has the receipt of such funds actually brought government interference, political influence, the threat or the reality of outside control? In other words, what price has been paid for receiving tax funds for the care of the indigent? Has the price been too high?

Postprandial Politicians

AT ALL times the hospital must beware of inadvertent or planned harmful legislation. To catch the public eye, more or less astute politicians often seize upon the hospital's acknowledged appeal to further their own particular fortunes. Moreover, to the exuberant politician, be he of the national or of the ward variety, no time or place appears inappropriate for a public dissertation on his personal or party policies. The cynical might suspect that such public utterances were prompted by a desire to advance his own private fortunes, while the gullible may interpret such oratory as an evidence of a patriotism so deep that in it personal greed plays no part.

Even the banquet tables of great hospital and medical associations are not exempt from this display of bad taste. To accept a speaking engagement at a scientific or institutional convention and to profiteer upon this hospitality in favor of a party or person would seem to represent bad judgment as well as bad taste. Institutional executives visiting in distant cities in quest of greater proficiency in hospital administration have little interest in a local political situation, or even in the interpretation of national ones, no matter how prominent the speaker.

Those who arrange such programs are little to blame unless they fail to impress the speaker with the type of his audience and to offer suggestions as to the nature and length of his remarks.

The recent spectacle of two large and expectant dinner audiences being bored by political harangues which lasted beyond the hour is inexcusable. Politics has no place within an organization nor should any brand of national or local politics be inflicted upon members met in annual convention. No doubt, those in charge of the next convention of the American Hospital Association will endeavor to prevent a repetition of this type of unpleasant occurrence which to many marred its last meeting.

Harmful Publicity

A RADIO news commentator recently scored a hospital for unfairness in refusing to accept a patient suffering with an acute inflammation of the vermiform appendix. The hospital, not believing the condition to be acute, had referred the case to an institution in the patient's own city to which he had been first directed.

Herein lies a nice point for the community to decide. Must a voluntary hospital accept every case which comes to its door irrespective of residence and ability to pay? Should the presence of an acute human need represent an open sesame to every hospital ward bed?

The answer is simple. No hospital administrator will wilfully endanger the life of fellow men within or without the institution. The acceptance of a patient with a contagious disease under most circumstances violates the hospital's obligation in regard to patients in the hospital, while hesitancy in admitting nonresident or indigent patients with acute ailments certainly fails to safeguard the welfare of such persons. The hospital is not legally required to accept without question all patients who apply but it should need no coercion to do its clear duty. When its duty is not clear, it must retain the right to decide on the urgency of the need as well as the effect on the welfare of those already under care.

A Rally Cry

By ALFRED E. SMITH

I DO not think that there is much doubt in anyone's mind that we need voluntary hospitals. The main problem seems to be to develop in each community a sense of responsibility for the maintenance of these institutions. As I see it, this is not so difficult in the small town, but becomes a major problem in large metropolitan centers.

I was talking the other day to a medical friend of mine who lives and practices in the upstate town of Potsdam. As he described the hospital situation in his community, I realized that it was really very similar to that of New York City, but with one notable difference — the people of Potsdam are keenly aware of it, most New Yorkers are not.

Potsdam has one sixty-bed hospital. It is a voluntary institution financed by individual contributions. The only other hospital in St. Lawrence County is at Ogdensburg and is a specialized institution for tuberculosis. In consequence, the Potsdam Hospital ministers exclusively not only to the town's six thousand inhabitants but also to the population of the surrounding countryside, numbering some thirty thousand.

From Bank President to Factory Hand

There is no need, in this community, to point out the importance of the voluntary hospital. Everyone, from the bank president to the factory hand, is fully aware that there is no other place for him to go if he has an attack of appendicitis, breaks his leg or wants his tonsils out.

In New York City, many of us are in the very same situation. If there were no voluntary hospitals, there actually would be no place for us to go for hospital care. Because we are not a closely knit community and because we know, in a vague way, that there are city hospitals, we do not realize this.

It is part of the job of the voluntary hospitals to make their service to the public so clear and so easily understood that those in the community who are able to give, will respond. We cannot shift the entire responsibility for hospitalization on the government, and even if this could be done, it would be merely passed along to the public in the form of increased taxation.

If the work of the voluntary hospitals cannot be clearly understood by the people and will not be supported by them, there is only one thing for the hospitals to do — go out of business. It is a shocking thing to realize that three hospitals in New York City during the past year were forced to close their doors. It is certainly distressing to know that, while hundreds of the city's poor need hospital care, beds in voluntary hospitals lie vacant, because there are no funds to maintain them. New York's voluntary hospitals represent an investment of approximately $200,000,000. When machinery in an industrial plant of such caliber lies idle, we are quick to recognize the economic waste involved. Certainly it is a far greater social waste to squander, for lack of operating capital, the machinery for human rehabilitation which lies within our hospitals.

Forward Movement Under Way

It is, of course, not my place to suggest detailed methods of overcoming this waste of capital values. Hospital experts are, I understand, giving it careful and studious consideration and are proposing such measures as group hospitalization (we New Yorkers call it the "three-cents-a-day plan"), increased service to ambulatory patients, development of preventive services, closer working relations with practicing physicians and programs of public education based on sound community planning. I am willing to leave the decision as to method to these experts in and associated with the hospital field.

But as a citizen I am deeply concerned that we take seriously our responsibility to keep faith with those who have generously and ofttimes at real sacrifice provided the money and the enthusiasm to build our hospitals. In spite of the great advances of the last few decades, we have not yet exhausted the possibilities of medical science and art. We can go much further in bringing the marvelous discoveries of medical science to bear on the day by day life of our people. Until we do this to the fullest extent permitted by the present facilities of our hospitals we are not fulfilling the trust placed in us by those who have provided these facilities.

Furthermore we can never rest. Hospitals are the tools with which the medical profession serves the public. As medicine advances our hospitals

must advance with it. We must provide in our hospitals those items of scientific equipment that the medical profession needs to do its best work. We must furnish the profession with the trained competent personnel that will most helpfully expedite its work. Good equipment and competent personnel cost money.

The noted former governor of New York, who is a trustee of the Beekman Street Hospital, is a staunch supporter of the voluntary hospital system

We who are trustees of hospitals, and I speak feelingly because of my long and happy association with Beekman Street Hospital, do take seriously our responsibility to keep our institutions abreast of the times. We are now realizing, however, more fully than ever before that a small group of trustees, no matter how respected and influential they may be, cannot do the whole job alone. We must enlist the whole community in the cause of good hospitalization and in the support of our voluntary hospitals. Only when we have laid a broadly democratic basis for hospital support shall we be on sure ground.

In New York we have recently proved again that the public can be interested in its voluntary hospitals. The United Hospital Fund has for many years been raising money for the support of the leading New York voluntary hospitals. But these funds were inadequate to meet the needs. Study of hospital needs in the New York region by several cooperating organizations has given us many basic facts about the situation. With these before us we decided to enlarge the work of the United Hospital Fund and strengthen its support of voluntary hospitals.

The results of this decision are now history. On behalf of eighty-one instead of fifty-six hospitals the fund has just succeeded in raising $1,850,000. Last year the fund's distribution to hospitals totaled only $500,000.

Survey Simplifies Procedure

We are still not content. Our goal this year was $2,000,000. Before next year's campaign we hope to have in front of us the results of the extensive survey of New York's hospital facilities now being made. This survey should give us a clearer picture of the needs and opportunities for service in this great metropolitan area. If, as may well be the case, we find that still more money must be had to meet certain important public needs, I feel sure that we can go before the citizens in this area and obtain their interest and generous support. We shall be all the more confident in our appeal because it will be based on the most careful kind of planning and research and will have been subjected to comprehensive criticism by all those who are concerned with the problem — hospital trustees and executives, medical societies, social welfare groups of various kinds, and representatives of the local government agencies.

Right here, I should like to put in a word about the necessity of cooperative action on the part of hospitals. I am sure that the citizens of New York City are today far more aware of the existence of their hospitals and have a much better appreciation of their services than they had before our recent campaign. This would not have been achieved — could not have been achieved — if each hospital had chosen to go its own way, disregarding all the others. What we have done in New York can be done on a smaller scale in any community that has several hospitals.

Why "Private"?

I believe it is an unfortunate thing that our voluntary hospitals have become popularly known as "private." I am told that there are 114 voluntary hospitals in Greater New York. These institutions are popularly called "private" hospitals because they have a few rooms devoted in good times to the care of prosperous patients. Today these institutions are really adjuncts to our municipal system, caring for a peak load of city cases because there are not sufficient beds in municipal institutions. They have more vacancies in their private rooms than our stylish Park Avenue apartments. During 1934, in fact, they gave 2,321,819 days of care to city cases. This is a tremendous job.

It is not enough to place cold figures before the public. I believe we must translate all these facts into concrete human terms. I think if all of us clearly realized that when, or if, we or our families are taken sick, we shall have to turn to the voluntary hospitals, we should all support them to the full extent of our ability. We must get away from the feeling that the government can do it all and summon up the public spirit, charity and generosity, which I know are inherent in the American people, to rally to the support of the hospitals which they so sorely need.

Somerset—Hospital County Seat

By RAYMOND P. SLOAN

A PATIENT bidding farewell to Somerset Hospital, Somerville, N. J., after a stay of several weeks unconsciously revealed its story. He stepped up to the desk separating the office from the attractively simple front hall to pay his respects, also his bill, which characterizes him at once as a superior patient. The ink was hardly dry on the check he had just signed when Mrs. Daisy Kingston, superintendent, entered her office in the rear.

"Pretty good," he replied cheerily to her inquiries as to his state of health — "Just a bit . . ."

"Uncomfortable, perhaps," someone suggested.

"That's precisely the word — uncomfortable, but," he lowered his voice, "I want to tell you what good care I received. Those girls upstairs certainly did everything possible to make it easy. Fine service throughout."

"By the way, Mrs. Kingston," he continued, "that's a pretty poor kind of a desk you have down there in the social service room. Not much better than a box. I tell you what. Some day soon you'll find one of the company's trucks backed up leaving a desk for you. I'm sure we have one at the plant which will be much better than that one."

"Not at all, not at all, glad to do it. Thanks again for the good care I got."

That new desk which is probably by this time being put to good use is symbolical of service—service efficiently rendered to the community. Its donor, an executive of a big manufacturing unit located in a neighboring town, represents in turn the community—hospital conscious and proud of Somerset, its hospital county seat.

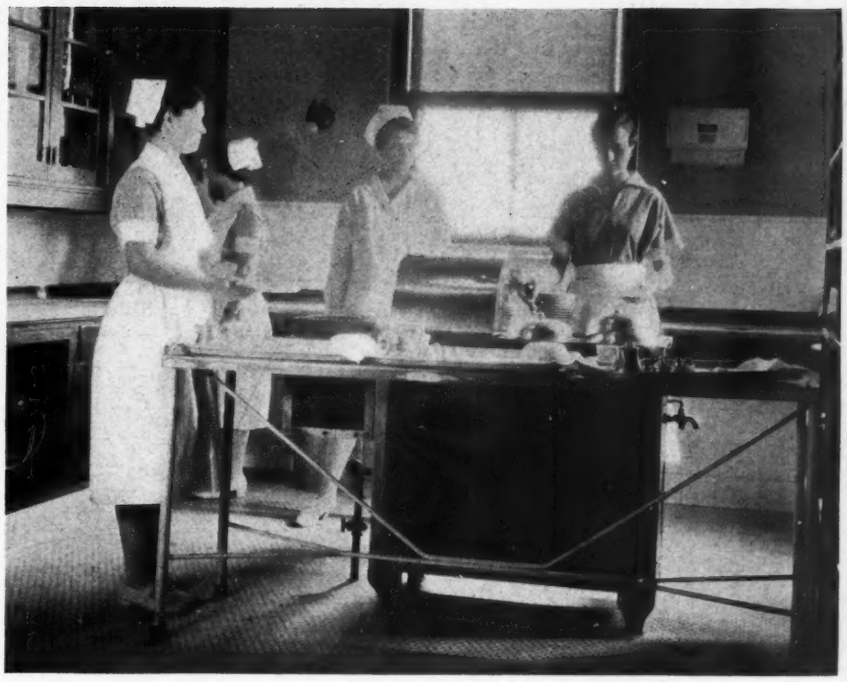
Much has happened during the past ten years to make the town of Somerville and neighboring communities in Somerset and Hunterdon Counties hospital-minded. The present building with an occupancy of eighty-six, including twelve bassinets, is the outgrowth of a small twenty-bed cottage hospital. Even in those days, leading citizens of the town, conservative members of the old Dutch colony, realized the need for hospitals.

Somerville has background. Surrounded by towns which have succumbed to trade and barter and from which come the sound of whirring wheels and the raucous roar of factories, it has remained strangely aloof from commerce. It has even refused to be impressed by the invasion of wealthy New Yorkers whose country estates dot the hillsides. It, too, has its wealth, and more. In some of its older homes may be found today furniture which was originally brought over from Amsterdam. Somerville, however, long ago set its own standards and has stood by them.

With this background, it was inevitable that Somerville, the county seat, should make Somerset, its hospital, a county hospital seat. This is precisely what has happened. All public health nursing and county health activities center at the hospital. Daily some twenty nurses may be seen coming and going, bringing patients with them, making reports and checking records.

Each year has witnessed new demands upon its

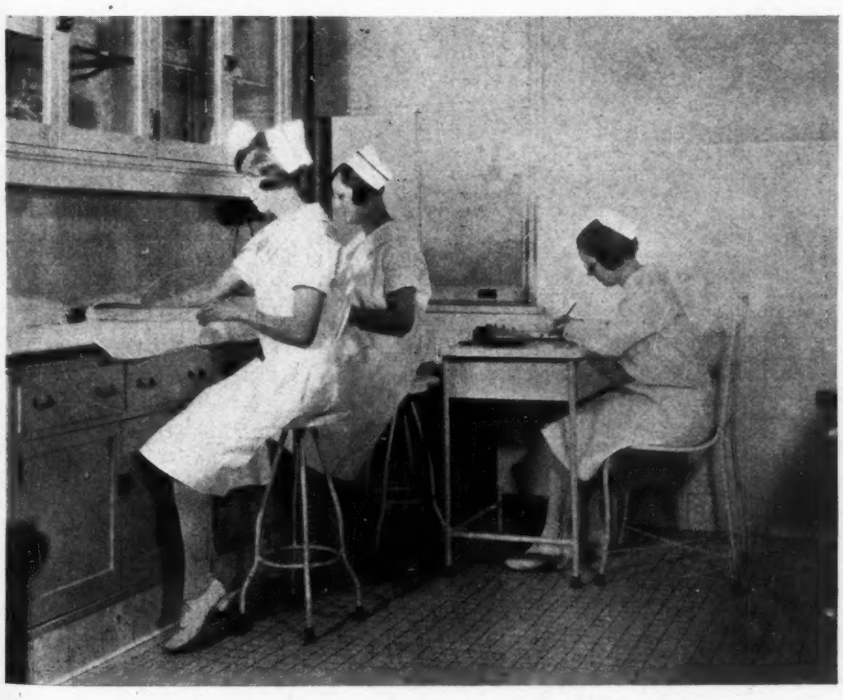
The dietitian has a student as assistant and one or two pupil nurses, seen here preparing tray service on the floor. The lower picture shows nurses folding gauze in the operating suite.



services as the following figures show clearly. In 1926, number of days of adult patient care totaled 12,331 and the hospital operated at a bed occupancy of 46 per cent. The ensuing years show—1927—15,414, 57 per cent; 1928—16,-731, 62 per cent; 1929—17,-763, 66 per cent; 1930—19,496, 72 per cent; 1931—17,621, 65 per cent; 1932—18,097, 68 per cent; 1933—18,468, 69 per cent; 1934—18,803, 70 per cent, and in 1935 adult care totaled 20,797 days with occupancy at 77 per cent.

Eight clinics are being conducted—mental hygiene, prenatal, venereal, orthopedic, pediatric, tuberculosis, medical and pneumothorax. Two mental hygiene clinics are held each month. Reports for a recent month show 8 patients and a like number of treatments. Prenatal clinics are held weekly, the same month showing 35 patients and 42 treatments. Venereal patients are also treated weekly, the month showing 35 patients and 32 treatments. The orthopedic clinic is held twice a week and in one month handled 74 patients who made 337 visits. Pediatric cases are treated once a week, the month showing 17 patients and 17 treatments. The tuberculosis clinic is held once a month when 13 patients received as many treatments. The medical clinic, which takes place weekly, handled 36 patients and gave 46 treatments. The pneumothorax clinic, just lately organized, is held weekly. In all, some 9,000 visits were made to the hospital's clinics in a year.

A small charge of twenty-five cents is made for clinical treatment, where it is possible to do so, but such occasions are few. The orthopedic clinic, for example, which is the largest of all, produced only $1.50 for one month.



History repeats itself. Just as ten years ago a twenty-bed building was insufficient so today an eighty-six-bed building can not meet the demand. Characterized by the same sound business judgment which has marked every step in the development of the hospital, its board is contemplating erecting in the near future a new wing which will relieve an already overcrowded maternity department, and supply additional private rooms, to say nothing of providing more space for the laundry and dining rooms.

The progress which may be traced year by year back to the very inception of the institution, may be attributed in large part to the fact that during the greater part of its life its managment has rested in the same hands—very efficient hands, too, as the records indicate. If for nothing else, Somerset is distinguished for the intelligent supervision it has received both from within and without and the close relationship existing between the two.

Mrs. Kingston will probably proclaim that her board is responsible. "There never was another like it. Or if there is, I have yet to hear about it." The board of Somerset repeats the same statement, merely substituting the word "superintendent" for "board." It is perfect teamwork.

What hospital superintendent has had the experience of being asked by the president of her board whether she has read a certain article appearing in the latest issue of the leading hospital journal? Mrs. Kingston would like to know. It has happened to her more than once, notwithstanding her efforts to keep abreast of the times along with her hospital duties and her association work, for she has for many years been active in the New Jersey Hospital Association, in which she has filled the post of vice president. It is very possible, for example, that her president will be the first to read this article. Who knows?

The business set-up of the institution is simple. Toward the close of each year, Mrs. Kingston appears before the finance committee with a formidable looking document in her hand. It comprises her tentative budget for the following year. It is possible, for example, that she will figure her estimated operating account at $124,000 as she did two years ago. Expenses of her administration department she placed at $8,852 which was broken down into labor at $5,130 and other expenses at $3,722. Professional care of patients was figured at $47,316, likewise divided into $27,736 for labor and $19,580 for other expenses. So on down the line: housekeeping, total $10,820, labor $5,820, and other expenses $5,000; dietary, $30,332, with labor at $5,300 and other expenses, $25,032; laundry, total, $5,680, labor at $3,580, and other expenses, $2,100; maintenance, total $21,000, with labor at $5,800 and other expenses, $15,200.

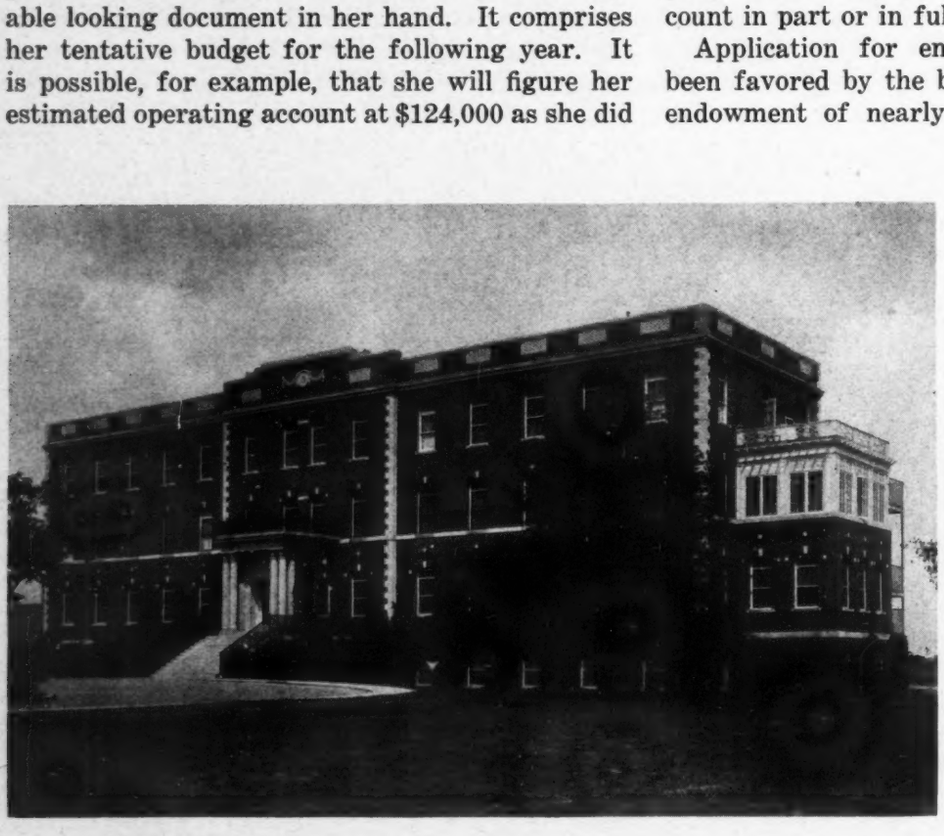
Once this budget is established, Mrs. Kingston receives a check each month for the amount required. Any difference which may result is made up by the board. That is, if hospital revenue for the month is particularly low, the necessary amount is given her to make up the difference. All revenue accruing to the institution is turned over to the operating account in Mrs. Kingston's name. She attends all of the finance committee meetings.

At the present time, free work averages about 52 per cent. During December, 1935, the hospital took in $8,459, and in the same month free patient day service figured about $2,840.

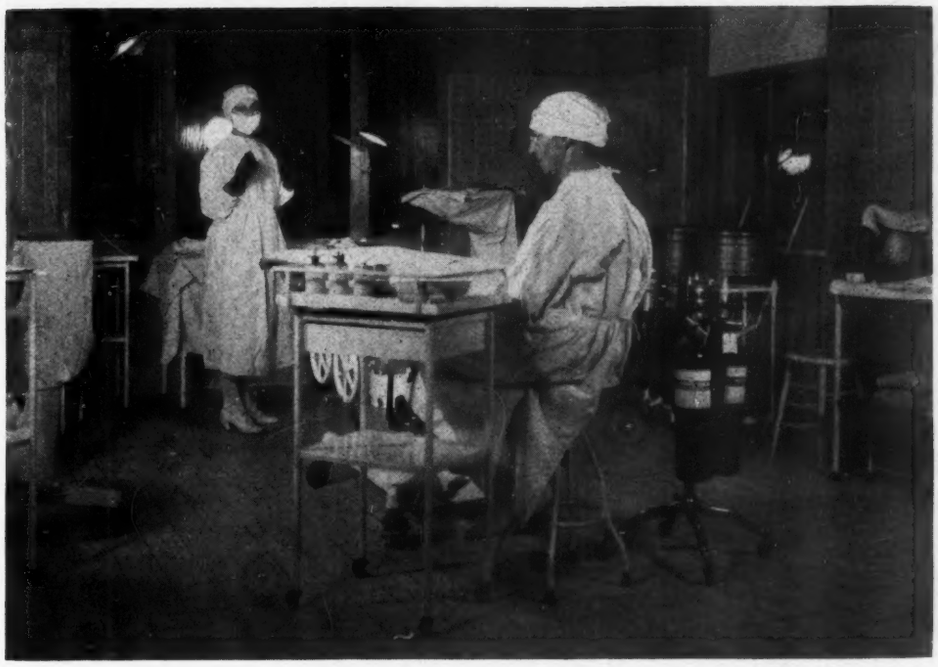
No payment for service is required in advance. The patient is admitted, following which it is determined what type of accommodation he should receive. The people for the most part are reliable, it has been found. They have enough community pride in the hospital to pay eventually their account in part or in full.

Application for emergency relief has never been favored by the board. The hospital has an endowment of nearly $500,000. In addition, it receives some $30,000 from Somerset County, also small appropriations from various townships. Then there are always funds raised by the women's auxiliary and miscellaneous gifts.

The women's auxiliary is particularly active, comprising some



Somerset, county hospital seat, which after ten years finds its facilities inadequate. In the near future a new wing will be erected.



Hospital operating room procedure at Somerset. To the little patient in the lower picture hospital life at Somerset does not seem so bad after all.

300 members. In addition to providing a large part of the appropriation for linens, its sewing committee helps with curtains and other miscellaneous work and its bandage committee makes dressings. It also furnishes an automobile, with maintenance, for the use of the social service worker. Its monthly meetings take place at the Civic League Building.

The character of the personnel, important as it is in every type of organization, plays a particularly major part in the success of hospital work. Through the years, Mrs. Kingston has surrounded herself with an efficient staff thoroughly versed in all hospital procedure and ready to take over additional duties should the emergency arise. It is interesting to see how the work is allocated.

Mrs. Kingston, in addition to her general managerial duties which place her in complete charge of the entire institution, does all the buying, with the exception of foods. As is indicated later, this is part of the function of the dietitian.

Two resident doctors are employed. The regular medical staff numbers ten, all of whom are men of high standing in the community. There are also thirty associates. The hospital is fortunate in being near enough to permit certain affiliations with Muhlenberg Hospital in Plainfield, N. J., which have been extremely helpful. The services of that institution's roentgenologist, for example, are secured on a part-time basis.

Pupil nurses form the backbone of the nursing service. These are for the most part local girls, again linking the hospital to the community. The school at present numbers forty-seven. An instructor is in complete charge of the school, and there is also a supervisor of nurses. The graduate nursing staff numbers twelve. The chief anesthetist, a graduate nurse, also acts as historian. The anesthetist assists the superintendent and also helps out in the office. One of the twelve graduate nurses assists in the office work. In fact, there is always a graduate nurse on hand in the office

to greet visitors. Full-time services of a social worker are required.

The dietitian is in complete charge of all food service and does all the buying for the department. She also assists with the housekeeping, to the extent of keeping time sheets of workers employed by that department and assuming charge of all the help. The supervisors on each floor are responsible for the proper maintenance of their particular floor. The dietitian has a student as assistant and one or two pupil nurses at all times

working with her on special diets. The kitchen staff consists of ten. All the cooking is done by women. In addition to the cook and her assistant, there are two dining room maids and two diet kitchen maids.

All the cleaning throughout the hospital is done by men, six altogether, who are occupied both inside and out. Two of these also act as orderlies, even assisting the doctors at certain times. There is also one general orderly for the house who goes out on the ambulance. A matron and two maids take complete charge of the nurses' home.

A night man and a day man are employed in the engineering department. The night man also does ambulance work. Then there is a general engineer and mechanic who does carpentry work. Two painters are employed the year around, but one of these does outside work and also works on the ambulance. A man manages the laundry with the assistance of six women.

Two technicians are engaged in the laboratory, one on x-ray and the other in the clinical laboratory. Their training is such that they are qualified to switch about.

The office force in addition to the assistance rendered by others on the staff comprises a bookkeeper and a stenographer.

Everything possible is done to protect the patient and to render him the most efficient service. The unit system of equipment is used throughout. To each patient entering the hospital is allotted every item he will need, including bedpan, washbasin, thermometer. These are kept at all times by his bedside or in his room.

A folder which is distributed to patients and their guests emphasizes the need for quiet. "Visitors," this reads in part, "are requested to be quiet and to avoid loud talking or laughing in corridors or rooms. Doors of patients' rooms must be closed during friends' visits, in order that other patients may not be disturbed. Nurses are expected to enforce quiet, and patients will please not embarrass the nurse in carrying out these instructions. Please do not ask the nurse questions about other patients, as she must not answer, and patients shall not visit other sick rooms, except by permission given by the supervising nurse." Attention in this same leaflet is directed to the food service available for patients' guests. "Arrangements may be made for meals, and a price of $1 for dinner and 75 cents for other meals is charged. Meals must be ordered two hours before they are served."

Contrary to the practice of some institutions, no special effort is made at Somerset to uncover complaints after the patient has left. The board does not believe in it. Moreover, it has been Mrs. Kingston's experience that complaints generally reveal themselves while the patient is in the hospital. Through contacts made with the patient by the superintendent of nurses and the dietitian, she is able to determine the attitude of those being served. Where dissatisfaction is reported, she investigates at once.

With such mutual understanding as exists at Somerset, there is indeed little opportunity for complaints. Then too, the hospital belongs to the people. It is administered by those they know and in whom they have confidence. It is truly the hospital county seat.

Further Protection in Automobile Accident Cases

During recent months the nation has been aroused over the great number of injuries and the loss of life resulting from automobile accidents, and various measures are being suggested to decrease this maiming and killing. Little thought has been given in this connection to the terrific burden placed on hospitals in caring for those injured. Is it not time that the hospital world became aroused and took steps to free itself from these financial impositions?

A large number of automobile accident cases leave the hospital with no thought of paying for service they have received. The story usually given by the patient is that he was not at fault and that the account should be settled by the other party to the accident. The other party is financially unable to pay, or, if he has resources, becomes involved in litigation and suggests that the court decide who should pay. The hospital waits many years for that, and eventually the account is forgotten, or a settlement is made out of court without the hospital's knowledge. Neither party to the accident takes any cognizance of the service rendered by the hospital, a service much needed at the time of the accident and one speedily and willingly provided.

Several states have enacted lien laws that protect the hospital in cases in which financial responsibility has been determined. This law has enabled the hospitals of these states to collect thousands of dollars on accounts which otherwise would have been charged to profit and loss. The hospital associations in those states not having such a law would do well to study the experience of those who have had one enacted.

While a lien law in every state will materially lessen this problem, it will not enable the hospitals to be reimbursed one hundred per cent for their services in caring for accident cases. Therefore, all hospital organizations should be an the alert to develop supplementary laws and means of curtailing this enormous drain on the hospital finances.—*Lucius R. Wilson, M.D., John Sealy Hospital, Galveston, Texas.*

In a Small Hospital
Does the Nurse Get a Fair Deal?

By EDNA H. NELSON
Superintendent, Women's and Children's Hospital, Chicago

I BELIEVE that students should not be accepted for a small school without having the advantages of a large school explained to them. If any girl of outstanding material with a college background approaches me, I refer her to a university school.

The hospital in the small community draws its applicants from the very small towns. Even though they are high school graduates, their preparation has been restricted because of limited curriculums in their schools. Many candidates come from farming districts and though we often hear that the strong, wholesome, country girl makes the best nurse, this is mere supposition. The nursing profession needs women who have the social background which gives poise, refinement and acceptability to patients. If such girls are available in small communities, it is because family obligations or financial reverses have made it impossible for them to enter larger schools.

Many worth while applicants have had to work throughout their high school courses as maids in homes. Often they remain in service for a time after graduation, to earn enough to enable them to enter a training school. If a girl goes to a large nurses' training school, who has secured her preliminary education that way, few persons know of it but in a small community it is never forgotten.

Usually the number of applicants for the small school is very limited so that the director cannot be too discriminating. Taking only average high school graduates may have to suffice when she would like to have those from the upper thirds of their classes.

Careful Choice of Students Essential

Until recently, because of the shortage of applicants, small hospitals were accepting more transfer students than large schools. Many of these students, possibly undesirables in their original schools, complicate routine procedures and class schedules, besides causing disciplinary problems. Because of the intimate contact in a small hospital, care must be used in the selection of nurses since one or two undesirables may cause much discord and be a handicap to the other girls who are putting forth their best efforts. The more careful the selection of students the less difficult will be the problem of adjustment.

Closely connected with this problem is that of the social aspect of the students' training. In the average small community cultural advantages are few. Moreover, because of the straightened finances of many of the students, they are unable to take part in any of the amusements and there arises a feeling of discontent and restlessness.

Social Life Must Not Be Overlooked

The social life of the students is much pleasanter if they live near enough to their homes to visit over weekends and half-days. However, care must be exercised that the few who do not have the opportunity for frequent visits to their homes are not overlooked. Organizations among the girls themselves, such as glee clubs or drama groups, are ideal if the girls have backgrounds enabling them to participate in and to appreciate them. These students also lack the broadening effect of meeting girls from various parts of the country. This helps to keep them provincial.

In small hospitals supervisors and head nurses are limited in number and their duties are often arranged to include more than one department. We frequently find, therefore, too constant association between the nurse and each supervisor. If there is any friction between them the student nurse may be placed in an unpleasant environment throughout her training, for it does not allow her the chance to get a new start in each department to which she is assigned. Although intimacy between supervisors and students is discouraged, it occurs more frequently in small schools than in large ones.

The major problem confronting the directors in small schools is the lack of excellent theoretical instruction supplemented with clinical experience. Usually we find the students absorbing the knowledge of but one person who may or may not be a trained teacher. Investigations have shown that

as many as twenty-two subjects are taught by the one instructor who obviously has little time for thoughtful study and teaching. In addition to her teaching duties this instructress may even have other work which makes demands on her time. There are few specialists in the small community, with the exception of ear, nose and throat men. These men may be well educated yet have little teaching experience, and they are seldom the capable instructors that the students should have. Few small schools have paid physician lecturers. It is often impossible to use volunteer service because the demand on the doctors who often have large rural districts to cover is too great, and much time would be lost in waiting for them.

Even were the theoretical instruction on a par with that of the larger school, much of the teaching depends upon the patients. The patients must present problems that challenge the students' intelligence and skill. Without a variety of cases, this cannot be accomplished. Try to compare the students in schools where the instructors teach or assist in teaching twenty-two subjects and where clinical experience is limited, with those in institutions that provide specialists for classroom work and skilled supervisors to help the students in understanding the abundance of clinical material. They are not comparable.

Every Nurse Should Know Obstetrics

It is rarely possible to give these students practical work in public health. Medical students in this country must have clinical experience in an out-patient department as well as in hospital wards. This is also an educational field for the student nurse but is not available in small hospitals. It takes its place next to public health in giving students an opportunity to get acquainted with the needs of the community.

Every nurse should know obstetrics practically as well as theoretically before completing her training, but few graduates from small hospitals really do. The number of deliveries for which they have scrubbed may be adequate for state requirements, but since these students do not have the advantage of a public health service or a prenatal out-patient clinic, they get little idea of the continuous supervision needed during pregnancy.

Much of the student's time is spent in a mixed service where the chance of securing well balanced clinical experience is usually slight. The state law regulates the number of major cases for which a nurse must scrub in the operating room, and it is sometimes necessary for a nurse to remain there waiting for cases, doing work that could be done by maids, though she has had the required number of weeks in the service. However, the opposite usually happens, since most small hospitals provide more surgical than medical experience, and if the student is especially good in this field she is allowed to remain in the operating room too long for a balanced training.

While the physical set-up of all small hospitals is not inadequate, in communities without competition the average hospital lacks some departments, usually the physiotherapy and the cardiac. Even though the hospital has an electrocardiograph or is willing to buy one, probably the staff members are not competent to use it. The students see more incorrect diagnoses and come in closer contact with inferior medical men as well as inferior methods of treatment. As a result, they frequently get the wrong idea of medical ethics and medicine in general. Professional jealousies may not be more pronounced in small communities, but certainly they are more conspicuous.

You may be wondering now, how can the small school give the same educational advantages as the larger one? It cannot unless it affiliates with a university or a large hospital in such courses as pediatrics, medical nursing, communicable diseases, psychiatry, diet therapy and public health nursing. To get a satisfactory connection is not always an easy task, and requires an alert and conscientious superintendent.

The small training school is less likely to have acceptable libraries, to provide house mothers to care for the social and health aspects of student life and to arrange for periodic health examinations. Few small hospitals have school physicians and students are privileged to choose their own medical advisers when sick. Personality, eligibility and other factors, instead of competency, may enter into the choice with serious results.

Small Town Problems

In large hospitals it is frequently unpleasant to dismiss students, especially if political entanglements occur, but in a small community it is even more difficult, for the entire community sometimes becomes interested. Because they know people so well, it is hard for the students to handle ethically questions asked of them outside.

Medical records in the small hospital are of great importance. What training should the hospital give student nurses in this field? Often, their cooperation is needed in the keeping of complete and satisfactory records. Frequently they do not have the advantage of seeing complete patients' records, especially if the hospital does not have an intern or house physician. The standards of the American College of Surgeons help to correct this situation.

There is also the question of whether the stu-

dents' own records are up to par. In the small hospital where the superintendent of the nursing school is also the superintendent of the hospital, training school papers may become confused with hospital data. In large schools with plenty of clerical assistance, filing clerks, and a system installed by experts this is not a responsibility of the nursing school director.

Many small hospitals do not employ dietitians, which gives rise to problems. Some institutions send their students to local high schools for a special course in dietetics and this causes more disturbance than if it were possible for the course to be given in the hospital. Even with a good affiliate course in this service, the students do not have the correct supervision on the floors for the remainder of their training.

During the past few years most small schools have decreased the number of student admissions. Many hospitals now have a combination student and graduate service. There are problems in all hospitals with this combination of nurses. In the small hospital they become more acute, for the graduate nurses sometimes show little respect for established routine, and, due to the close association, students are likely to be influenced by their example.

We hear a great deal about the comparative cost of graduate and student service in the small hospital. Recently there has been a gradual awakening to the fact that student nursing service does cost the hospital considerable money. It is necessary for the small training school to admit more students than it needs, for later many are away for months securing affiliations. This makes an added expense and causes difficulty in arranging class schedules. However, since so few hospitals have separate budgets for their schools of nursing, it has been extremely difficult to obtain accurate figures for comparison. We do know that a properly maintained school is more expensive to a small hospital than a graduate service. Since the educational requirements as outlined by many state boards are perilously low, wide-awake board members acquainted with the laws and knowing that their schools are far above the minimum standards are hard to convince that they should discontinue the nursing school.

It seems to me that the small training school is being unfairly blamed for the abundance of poor material on the market. There are many relatively small schools with excellent educational programs. The large school graduates ten to fifteen times as many nurses as the small school, and the percentage of misfits is likely to be the same from both schools. It is, however, difficult to see how a hospital with a daily average of less than fifty patients can, even with the best intentions, give a varied and sound nurses' training. Yet small schools offer many advantages. They help keep the doctors abreast of scientific advancements; they provide the community with good nurses who could not go to distant schools and they are a source of interest and pride to the community.[1]

[1]Read at the Institute for Hospital Administrators, Chicago.

Liability of Mental Hospitals in Suicides of Patients

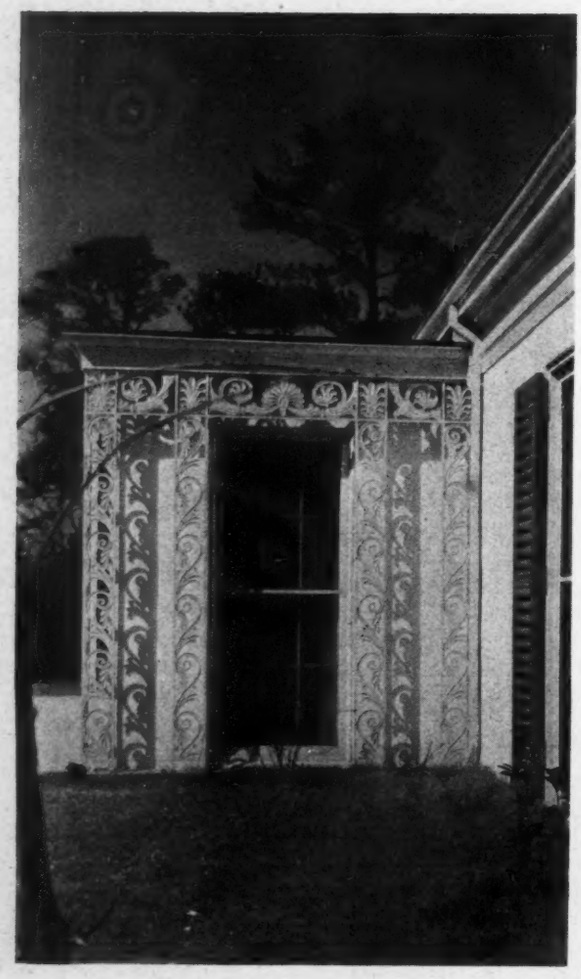
The patient's case had been diagnosed as manic-depressive psychosis accompanied by suicidal tendencies, and, on the advice of the physician, he was placed in a sanatorium from which he escaped and committed suicide. The plaintiff, as administrator of the decedent's estate, sued the defendant sanatorium and the jury returned a verdict for the plaintiff. A motion to set aside the verdict was denied and the defendant appealed to the Supreme Court of Errors, Connecticut.

From the evidence, said the court, the jury was justified in concluding that the decedent was suffering from a manic-depressive psychosis and that the sanatorium authorities knew, or should have known, in the exercise of reasonable care, that the decedent would commit suicide if the opportunity offered.

The sanatorium contended that it could not be charged with negligence since the decedent had not been committed to its custody by any court, that there was no evidence of voluntary submission to restraint and since the institution had no right to restrain the decedent, his escape and suicide did not render the defendant hospital liable for negligence.

In Mulliner v. Evangelischer Diakonniessenverein, 144 Minn. 392, 175 N. W 699, said the Supreme Court of Errors, it was stated that when a patient enters a hospital maintained for private profit he is entitled to such reasonable attention as his safety may require, and that if he is temporarily bereft of reason and is known by the hospital authorities to be in danger of self-destruction, the authorities are in duty bound to use reasonable care to prevent such an act.

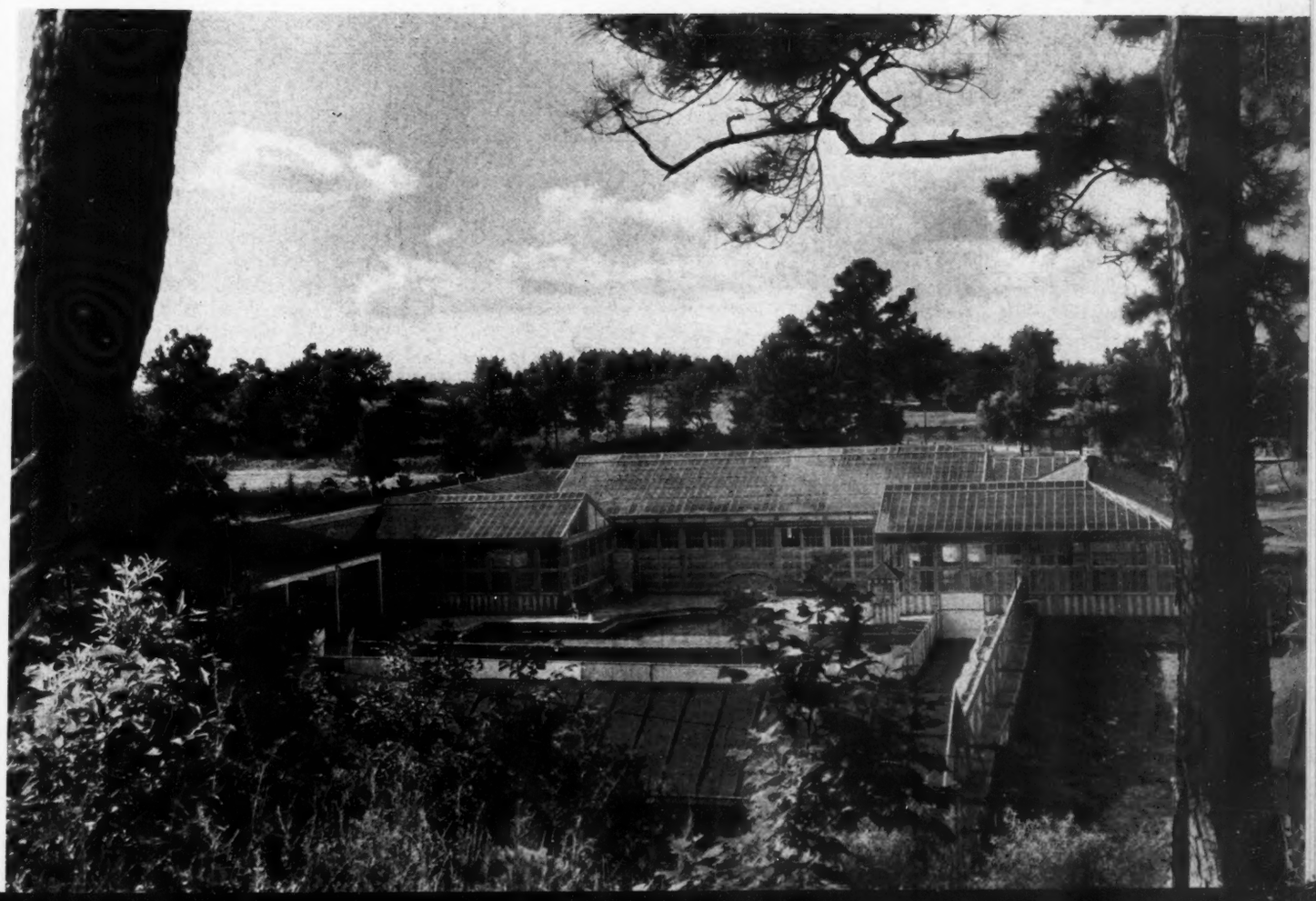
The Connecticut court agreed with the Minnesota court, and held that even if the sanatorium could not have legally restrained the decedent and prevented his leaving the building, it did not follow that they were not negligent in failing to have an attendant with him when he left the institution. The sanatorium had assumed, for a consideration, the duty of keeping the decedent under surveillance, and the suicide was a result of having failed to do so. Whether the sanatorium had exercised reasonable care under all the circumstances was for the jury to determine, and the court concluded that the findings of the jury were not so unreasonable as to warrant interference with the verdict and that the trial court did not err in refusing to set that verdict aside.



Hope Springs at W

SITUATED at the base of Pine Mountain, a foothill of the Appalachians, the warm springs, one time favored for bathing by the Indians and later a resort for the people of Georgia, now pour forth hope for the victims of infantile paralysis as generously as they pour forth their buoyant water. The Georgia Warm Springs Foundation, a development of the past twelve years, has become a center for after-treatment and research on polio patients. Here are shown its outdoor swimming and treatment pool and the conservatory like building which houses the indoor pool. The outer ends of Kress Hall and Builders Hall, newest of the group of buildings in the Southern Classic Revival Architecture adopted by the foundation, demonstrate the use of grade entrances to lower floors. The Doric columns enhance the entrance to Kress Hall which contains the comfortable living room. The iron grille detail is on Builders Hall. (Illustrations by courtesy of Charles F. Neergaard, New York City, the consultant on this project.)

at *Warm Springs, Ga.*



Someone Has Asked—

Should Department Executives Grant Discounts?

There are two items of policy in the above question — granting allowances for charity patients and granting them for courtesy patients. These policies should be defined by the board of directors and issued in writing to the executives in charge of the different professional services, such as x-ray, laboratory, physiotherapy or anesthesia.

It is a fairly general practice to permit allowances for members of the clergy and their dependents, as it is to permit them to hospital employees, graduate nurses and the medical staff and its dependents. This generally takes the form of a percentage reduction in the regular charges and can be authorized by those in charge of the different professional services or by the general office when sending out accounts. The account should be rendered in full with a special notation on it to the effect that an allowance has been made.

Allowances for charity patients or others should only be authorized by the chief executive officer of the hospital or some officer delegated by him for that purpose.—A. K. HAYWOOD, M.D.

Shoud Gas and Oxygen Anesthetics Be Given to Ward Patients?

This question was asked by the director of a hospital in which approximately five thousand dollars is spent annually for gas and oxygen.

Oxygen and nitrous oxide gas are expensive and the tendency to employ them routinely in the hospital appears to be on the increase. However, few superintendents have paused long enough to compute the hourly expense of gas and oxygen, ether and chloroform. The cost of spinal anesthetics, ether and oil for rectal cases, and novocaine, procaine and other local anesthetics is less difficult to estimate.

Gas and oxygen from an ordinary machine not equipped with a rebreather costs from two to three dollars an hour. This variance depends on the skill of the anesthetist and on the proper functioning of the machine. Ether costs from thirty to thirty-five cents an hour, spinal anesthesia approximately fifty cents per injection and ether and oil anesthesia approximately twenty cents per operation. The question arises in the consideration of these figures whether it would be fair to limit ward or nonpay patients to ether and to use gas induction or continuous gas and oxygen on those who are able to reimburse the hospital for this luxury.

No anesthetic should be withheld from any patient, free or full-pay, which would hasten his recovery. On the other hand, since ether is a safe drug and has few contra-indications, it seems logical to withhold an anesthetic costing three dollars an hour in favor of one costing one-tenth as much. The hospital should always be prepared to supply the needs of a particular patient, but in the present economic stress an institution that can render proper surgical treatment with the expenditure of less money is justified in so doing. Certainly it seems proper to switch to ether as soon as the anesthetic state is properly induced by gas.

In one institution the introduction of rebreathers has greatly reduced the cost of gas and oxygen anesthesia, approximately two hundred dollars each month being saved thereby. Since the original expenditure necessary for the purchase of this addition to the gas apparatus is approximately two hundred dollars, no doubt should exist as to the economic wisdom of its installation.—J. C. D.

Can Small Hospitals Supervise Their X-Ray Departments?

Roentgenologic examination and the interpretation in terms of pathology of data obtained therefrom is practice of medicine. Lay assumption of this function jeopardizes the welfare of the patient. Fluoroscopy and therapy by laymen invite disaster. Efficiency in the x-ray department that has adequate equipment and the cooperation of the hospital management, is in direct ratio to the executive and professional capacities of the medical director. Small hospitals may arrange for such medical direction by the following methods, named in the order of their desirability.

1. One radiologist may serve two or more institutions in the same community.
2. A radiologist from a near-by city may assume control of the department.
3. An intelligent and industrious physician on the staff may be selected as department head with the understanding that he will acquire sufficient knowledge of the subject to realize his own limitations.

A plan which permits each member of the staff of a general hospital to do his own radiology is pernicious, especially if the service is extended beyond traumatic emergencies. The department should be abandoned rather than that other diagnostic and therapeutic measures be curtailed by a false sense of radiologic security.—G. W. MURPHY, M.D.

Should Hospitals Admit Moribund Private Patients?

Many patients expire in the hospital in less than forty-eight hours following admission. In some instances such cases have received extensive trauma as a result of industrial or automobile accidents. A goodly number suffer from acute surgical states and succumb after an emergency operative interference. However, too many represent hopeless cardiorenal conditions or other terminal states in which the hospital and its staff have not even a chance to save life.

Some physicians, it is suspected, prefer to have a patient expire in the hospital rather than in the community in which they practice. This feeling represents a desire to pass a part or all of the responsibility for the death over to the hospital. Relatives are too eager to grasp at a therapeutic straw and to expect miracle working by the hospital.

Moribund patients should not be brought to the hospital. It is not fair to them or to the institution. To increase the mortality statistics of the hospital unduly in order to satisfy the false hopes of relatives or to serve the interests of the doctor is poor practice.—J. C. D.

Should Clinical Charts Be Removed From the Record Room?

A request frequently made by the physician is to be permitted to remove from the record room the charts of patients whom he has treated. It seems that such a request ought to be immediately granted, and yet this cannot be routinely done.

These records are first of all the

property of the hospital which is responsible for their safe keeping. If lost, the consequences to the patient and the hospital may be most embarrassing. Physicians, unfortunately, with the best of intentions, often fail to return clinical records promptly and sometimes not at all. Records become soiled and important laboratory sheets are lost or inadvertently destroyed.

Sometimes doctors who have not treated a patient during a hospital stay desire to peruse his chart, usually for bona fide, sometimes for questionable reasons. This privilege should never be granted without the permission of the physician who compiled the chart and that of the patient himself. Suitable accommodations for the study of clinical records should be provided by the hospital. When this is done there is no excuse for the removal of charts from the institution.

If charts are taken to the doctor's home or office, a proper receipt should be required and a maximum period of approximately two weeks allowed for the study of the charts. Unless strict adherence to such a rule is required, important clinical data will be dissipated and the hospital will deserve the censure of courts of law when charts are subpoenaed, and are reported as missing or incomplete.—J. C. D.

What Warrants the Dismissal of a Graduate Nurse?

Certain reasons sufficiently serious to warrant the dismissal of a graduate staff nurse are moral obliquity, disloyalty, inefficiency, unkindness and lack of conscientiousness in the execution of duties. These should be determined upon the same basis that similar conclusions are in relation to other positions of equal responsibility and importance.

A nurse's leisure time should rightly be directed according to her own inclinations and should not be interfered with by the administration unless that governing body feels her activities are casting an undesirable reflection upon the institution which she represents. Every story has two sides and some three; therefore a meticulous unprejudiced investigation should be made before final judgment is passed. Don't be arbitrary, be courageous. Weigh the matter from a humanitarian as well as from a professional standpoint, keeping foremost that "the patient must be the first consideration." If the nurse's past record seems to indicate that she is worthy of another opportunity, give it to her in your own hospital.

Unkindness is unforgivable as well as unforgettable and the patient should not be subjected to it. Any hospital can be justly criticized for retaining staff members found guilty of such unkindness. Regardless of how technically efficient a nurse may be, all is wasted if she is unkind either in deed or manner. Hospitals are judged more or less by the quality of nursing service rendered the sick. Too much concern cannot be exercised in the selection of personnel.—LOIS B. CORDER.

Who Should Purchase for the Small Hospital?

Purchasing in the small hospital should be done by one person. If the superintendent does not have ample time, this important responsibility should be placed on one who is thoroughly familiar with hospital supplies and will take time to make a special study of the merchandise that he asks his co-workers in the hospital to use. The principal reasons for failure, as given by Dun & Bradstreet, are overbuying, insufficient capital, extravagance and poor judgment. They often all mean poor buying. It is one of the most dangerous risks to which any business is subjected. Certainly such an important work should not be handled promiscuously by any and everyone in the hospital.—E. M. COLLIER.

Can the One-Man Hospital Be Efficient?

Strangely enough, this question originated from a nonmedical person in a Western community where the local hospital is headed by a physician and surgeon who performs all types of surgery and treats all kinds of medical conditions. It is, therefore, a pertinent question. The hospital has no visiting staff; community physicians send their patients for treatment by the surgeon-superintendent.

It is impossible in this modern day and age for any one man to be fully proficient in all branches of medicine and surgery. For example, the science and art of medical diagnosis and treatment requires a lifetime study before competence is attained. Newer developments in abdominal, chest and brain surgery have necessitated the development of specialists within this type of work. It does not seem possible for a surgeon to perform major operations in the morning and to interest himself properly in the treatment of pneumonia, nephritis or endocarditis in the afternoon.

The MODERN HOSPITAL believes that the reference of all types of medical work to one individual is neither a safe nor an efficient method of treating the sick. It is recommended that in this community an effort be made to organize a visiting staff and to develop properly trained specialists among them to whom shall be assigned the diagnosis and treatment of the diseases corresponding to their specialty. No superman has as yet been discovered who can encompass the whole field of medicine efficiently.—J. C. D.

How Enforce Recording of Preoperative Diagnosis?

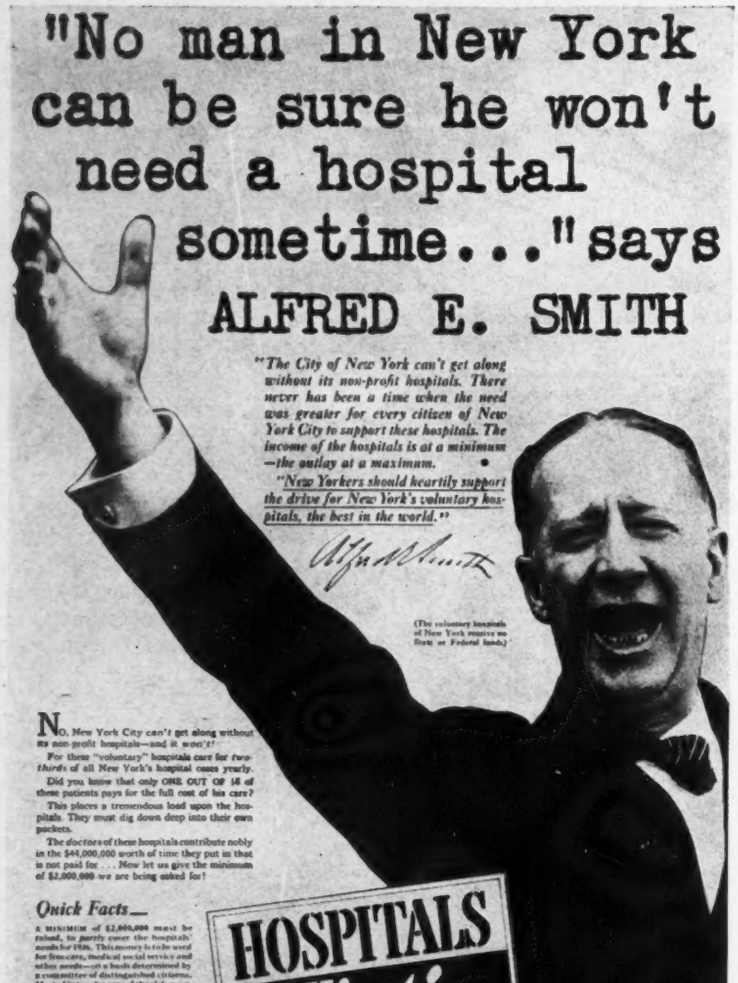
The operating room supervisor must be definitely instructed without any powers of modification to refuse to send for patients until the preoperative and history requirements are met. If the governing body through the superintendent enforces this ruling rigidly for a short time the procedure will become automatic.

A friendly way to bring this about is to have some member of the clerical staff type in the preoperative diagnosis on the "Report of Operation" as taken from the daily bulletin of operations. This can be done at the time the bulletin is made up which is in the majority of hospitals between the hours of 6 p.m. and midnight of the day preceding the operation.

When a preoperative diagnosis has not been given, the words, "Not Given" or "Not Made," should be recorded. In this way the incomplete record comes before the staff for review and the offenders can automatically be dealt with by the staff. At the same time it prevents the habit of writing the preoperative diagnosis afterwards.

The problem if dealt with properly by the hospital is only a minor one.—LEONARD SHAW.

If you have any questions to ask, the Editors will be glad to discuss them in a forthcoming issue



Hospitals First?

By MAXWELL HAHN

Director of Public Education,
United Hospital Fund of New York

FOR the first time in their lives many of New York's seven millions are hospital-conscious. Their discovery of the voluntary hospitals came through the recently completed United Hospital Campaign in which $1,852,821 was raised.

During the last five hectic years, the hospitals as a group sat back and let the various welfare organizations tell their story to the public. The hospitals were ignored and consequently suffered financially. The situation was so bad that one historic institution whose services were needed had to close for lack of approximately $20,000 to meet urgent bills.

In this situation publicity was not optional if the hospitals were to get public support.

Last spring the hospitals began in earnest a campaign of public education. There was no attempt to fire frequent shots. Rather the emphasis was on a few events which would be sure to make an impression.

From this deliberate start, the publicity was built up for the greatest maintenance campaign for hospitals in New York's history. The total gifts are four times the amount raised by the United Hospital Fund in its customary mail appeal campaigns.

The recent campaign has been New York's greatest community effort for the hospitals. Five thousand people were actually in the field soliciting gifts for the free care and below-cost care in eighty-one voluntary hospitals.

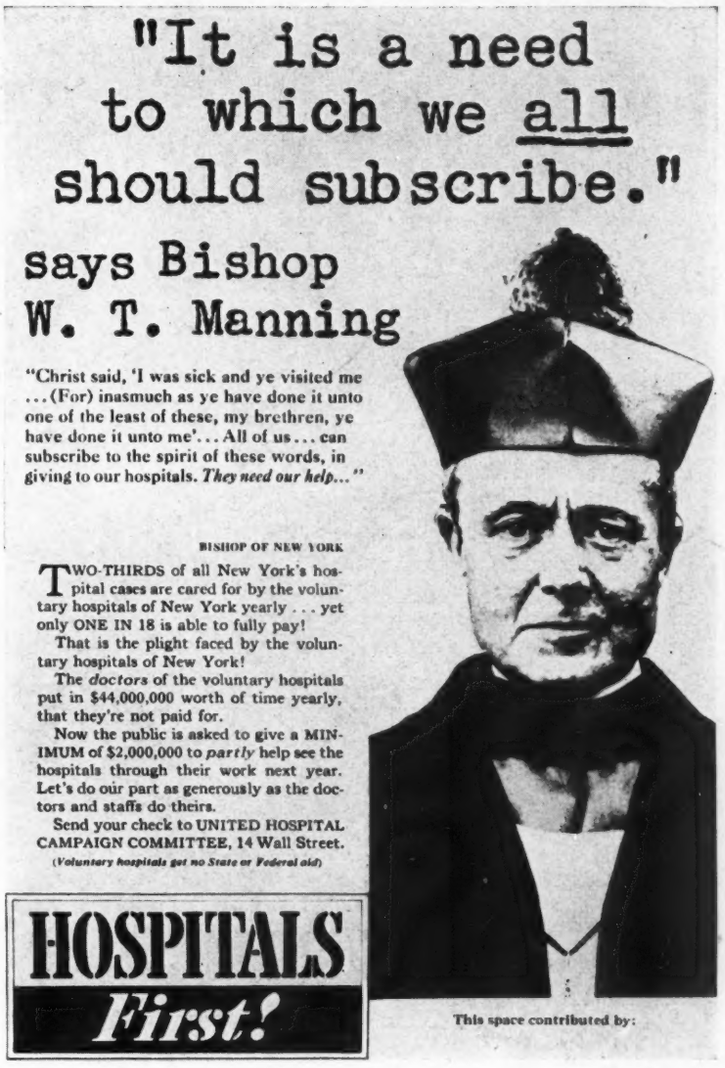
A hospital administrator expressed his view of the campaign thus:

"If there hadn't been a nickel raised in New York's United Hospital Campaign, it still would be the best thing that ever happened to the hospitals here. New York is talking about the hospitals now. The man in the street is beginning to appreciate what the hospitals mean to the community."

Better than any statement on the number of columns of newspaper space devoted to the campaign as an index to its success is the number of other groups which have tried to ride along on the hospital band wagon. But most pleasing of all is the fact that the United Hospital Fund has kept the confidence of the newspapers throughout the campaign and at the conclusion was receiving many calls for information and requests for help in developing various news articles which would be beneficial to the hospitals as a group.

There are several outstanding features of the campaign that may be adapted to the use of groups of hospitals or even of individual hospitals throughout the country. The hospital tour is one

New York Says "Yes!"



of these. This was used successfully prior to the opening dinner of the campaign. Former Governor Alfred E. Smith, himself a hospital trustee and vitally interested in the continuance of the voluntary hospital system, Gates W. McGarrah, internationally known banker and chairman of the campaign, and W. Lawrence McLane, assistant to the vice chairman, spent an afternoon visiting four hospitals.

Not only the photographers but news reel cameramen were waiting at St. Vincent's Hospital when the inspection party arrived there to see the overcrowded clinics and to visit the children in a convalescent ward. Governor Smith cheered the children by placing his brown derby on the head of a boy who had been in the hospital eight months suffering from a heart condition.

At Roosevelt Hospital an emergency case was brought in, taken into the operating room, given a transfusion and run through the various procedures of a typical emergency case. Of course, this all was previously arranged.

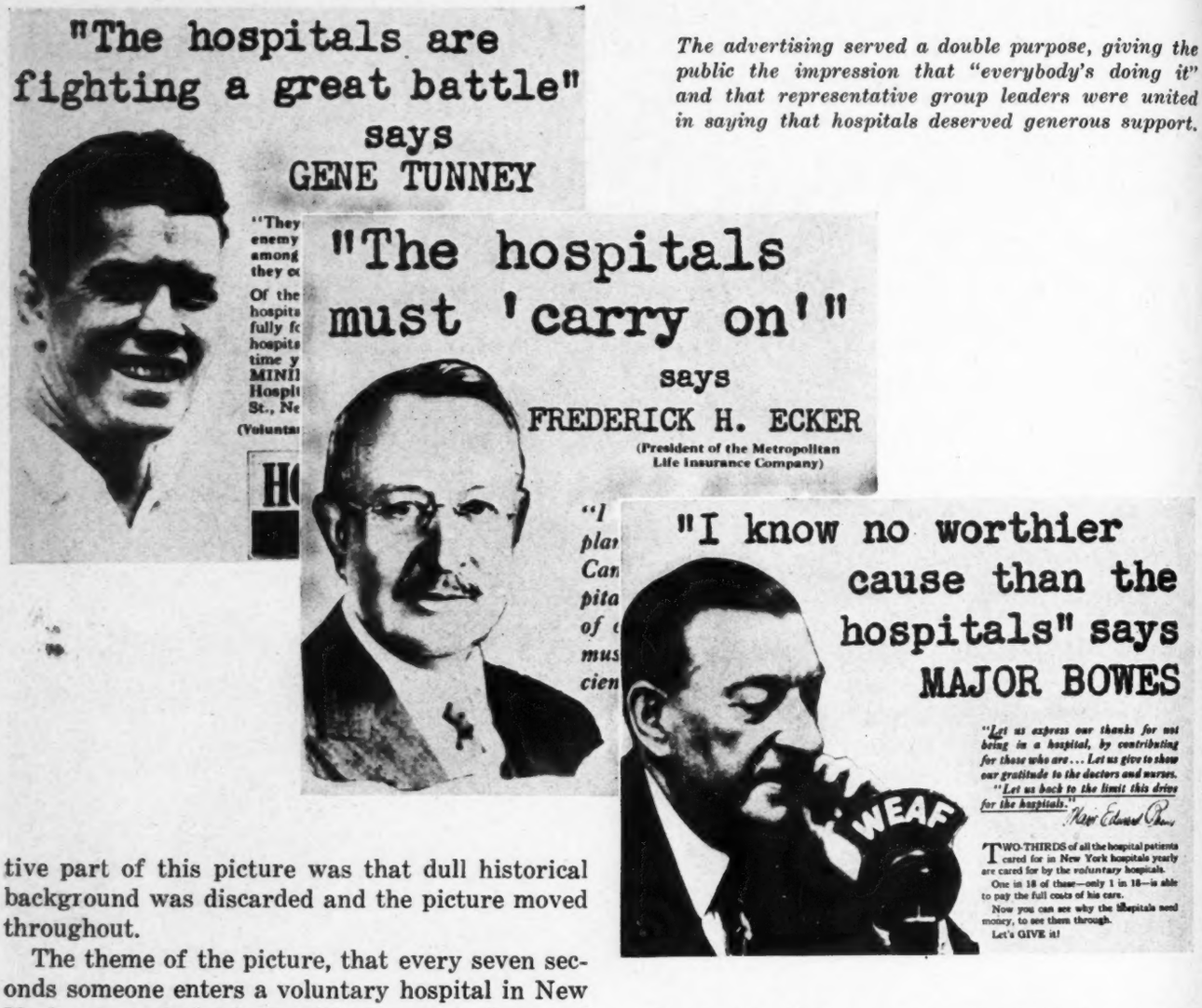
At Mount Sinai Hospital the emphasis was placed on the research work and prevention of disease which may be accomplished in hospital laboratories. Mayor LaGuardia, who was in the hospital at the time, had a short visit from Governor Smith.

At Flower and Fifth Avenue Hospitals, which jointly occupy a building, the group inspected the kitchens.

This hospital inspection idea was used by the Brooklyn division of the campaign and also to take the special gifts committee through New York Hospital in the company of David H. McAlpin Pyle, president of the United Hospital Fund and Mrs. William Woodward, chairman of the campaign women's division.

Careful planning is necessary for a hospital tour. Those arranging the event should travel the entire route beforehand to know exactly what problems will be met in taking visitors through the institutions. An effort should be made to spend little time on medical record libraries and other parts of the hospital, which may be exceedingly important but not very interesting to the outsider.

An excellent sound motion picture of hospital work was made and screened approximately 250 times to audiences probably exceeding 100,000. Two features made this picture successful. First the narration was by Mr. Pyle, the president of the United Hospital Fund, who has a perfect personality for the screen and an excellent voice for sound recording purposes. The second distinc-



The advertising served a double purpose, giving the public the impression that "everybody's doing it" and that representative group leaders were united in saying that hospitals deserved generous support.

tive part of this picture was that dull historical background was discarded and the picture moved throughout.

The theme of the picture, that every seven seconds someone enters a voluntary hospital in New York, was emphasized with frequent shows of the feet of people entering and leaving a hospital. The picture traced a call for an ambulance from Times Square to the hospital: the ambulance dash to pick up the patient; transfusion and emergency treatment where seconds count. There were shots of a fluoroscope in use; electrocardiographs; basal metabolisms; a doctor using the stethoscope and a sound record of a human heart beat; crippled children learning to walk, and the after care of poliomyelitis patients, including treatment in a therapeutic pool.

There were pictures of an actual operation, of social service workers interviewing patients, of a nursery, the training of nurses, the preparation of food, of the laundry and the power plant.

The picture was sufficiently well tied together by Mr. Pyle's narration so that abbreviated versions of it were shown at Radio City Music Hall, the Trans Lux Theater, Roxy's, the General Electric House of Magic as well as various neighborhood theaters. But from the campaign point of view, the movie's greatest use was for display at meetings of committeemen and prospects.

The heads of the various city departments became exceedingly enthusiastic about the picture and had there been sufficient prints and available projectors, would have shown it to all police, firemen and other city employees. The picture, however, was shown to selected groups of city employees so far as it was available.

The sound track was an important contribution to the realism of the picture.

There is no doubt that, in communities where the budget will stand the expense, a good moving picture is worth while. But better none at all than one which drags.

Endorsements of the hospitals by representative New Yorkers were used most successfully in a series of advertisements. The copy for these was prepared without charge by Stanley Resor, our chairman of advertising in his big agency, the J. Walter Thompson Co., and the space was donated by representative advertisers such as the banks, utilities, food companies and department stores. Every advertisement carried the words "The voluntary hospitals of New York receive no state or federal funds."

One advertisement quoted Mrs. James Roosevelt, mother of the president, "Support for the hospitals should be our first thought. In the present day and age, when so many cannot afford to pay the costs of medical care, it is especially important that the hospitals be supported. They give a service which is indispensable for our community. . . . They cannot be allowed to lower their standards."

Eddie Cantor's smiling face was in a two-column ad which said, "It's tough being sick — even if you have money . . . but believe me it's a whole lot tougher when you have no money. Be on the giving end and thank God you're not on the receiving end."

"Of course I am in favor of hospitals," was Gracie Allen's message, "my poor aunt has been in a hospital now for eight years. Of course she's not sick, she's a nurse there, but her patients are sick . . . and then again I like hospitals . . . and then again I like my aunt, and then again I like George. . . . You know what I mean, George?"

Mayor Fiorello H. LaGuardia was quoted with this endorsement, "Every New Yorker should support his hospitals . . . by this I mean every New Yorker who is not himself in need. . . . The voluntary or nonprofit hospitals of New York care for two million New Yorkers yearly. They do a service which the city hospitals cannot themselves perform. They should enlist the support of every solvent New Yorker."

Leading Men Give Support

Others whose statements about the need for community support of the hospitals were published included Alfred E. Smith, Bishop W. T. Manning, Grantland Rice, Felix Warburg, Rabbi Jonah Wise, Gene Tunney, Frank L. Polk, former Undersecretary of State, Frederick H. Ecker, president of the Metropolitan Life Insurance Company, John W. Davis, Rabbi Stephen S. Wise, Thomas J. Watson, Arthur Lehman and Dr. Harry Emerson Fosdick.

Another advertisement showed a boy in a fracture bed with the headline emphasizing that two-thirds of all the city's hospital cases are cared for by the voluntary hospitals.

A transfusion scene had the heading, "The doctors contribute $44,000,000 worth of their time."

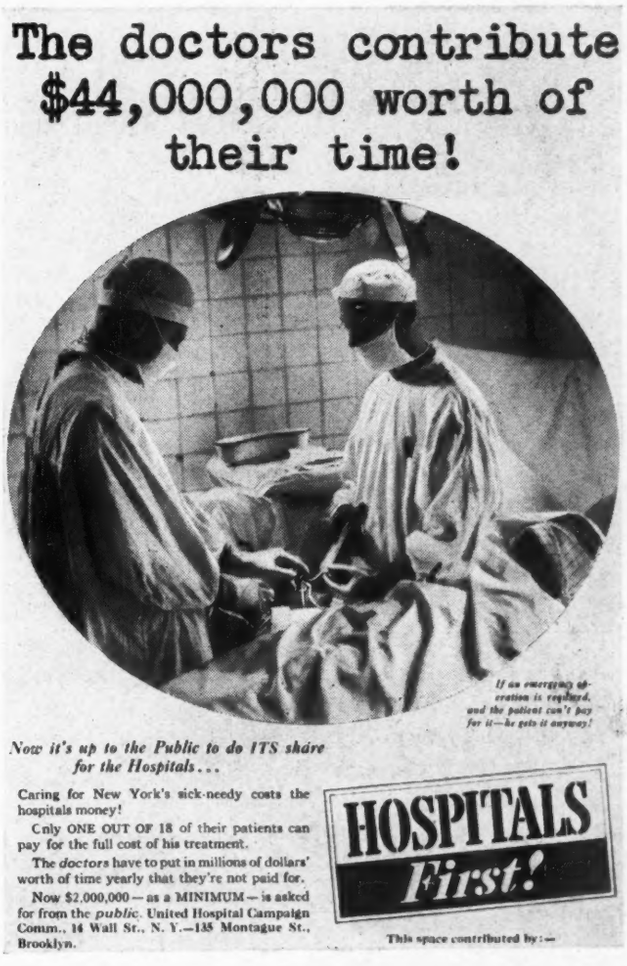
A throat clinic picture carried the heading, "Only 1 out of 18 can pay for the cost of his care."

To illustrate the expense involved in equipment, a boy was pictured in an oxygen tent under the headline, "Saving lives costs money. If the hospitals don't have the most expensive up-to-date equipment — lives are sacrificed."

A four-column advertisement without illustration, presented the facts of the hospital problem — what a voluntary hospital is — what percentage of the patients pay — who makes up the difference — the doctors' contribution of time, and the amount needed for 1936.

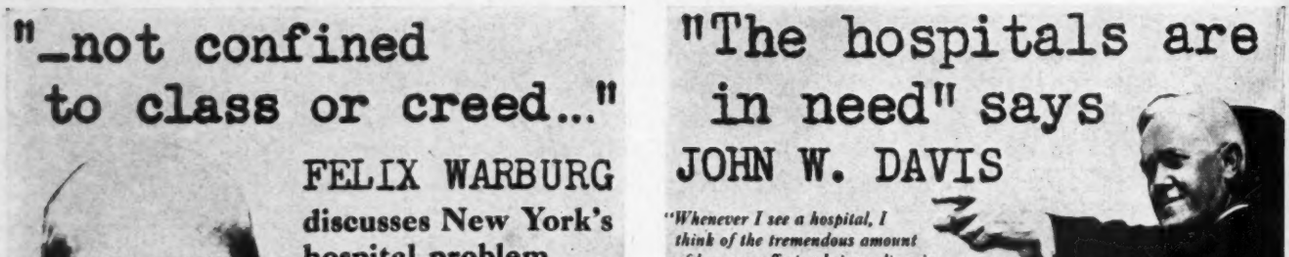
These advertisements which appeared in newspapers and magazines with metropolitan circulation, emphasized one of two slogans, "Unite for Our Hospitals," and "Hospitals First."

Supervision of the advertising program and solicitation of space was in charge of Arthur DeBebian, second vice president of the Chase National Bank. He was assisted by representatives of certain advertising agencies and of various metropolitan newspapers. Thomas L. Greer of the J. Walter Thompson Company was production manager. Nearly 3,000 columns of advertising appeared in the daily and weekly newspapers,



trade and class publications, foreign language papers, theater programs and magazines.

Twenty-four sheet posters were displayed on 315 billboards throughout the city. During the peak of the campaign, car cards were used in the subways, surface lines, elevated lines, busses and many of the suburban trains.



A huge bulletin, 9 by 12 feet, was placed on the lawn of the public library. Another printed bulletin, 18 by 25 feet, decorated the wall of the Long Island Railroad station.

Approximately 8,500 window cards were used in chain stores and 12,000 taxicabs carried hospital slogan stickers.

This advertising served the double purpose of giving the public the impression that, "everybody's doing it," and that representative group leaders were united in saying that hospitals deserved generous support.

The campaign booked more than sixty radio periods ranging from five minutes to fifteen minutes on all the radio stations in New York.

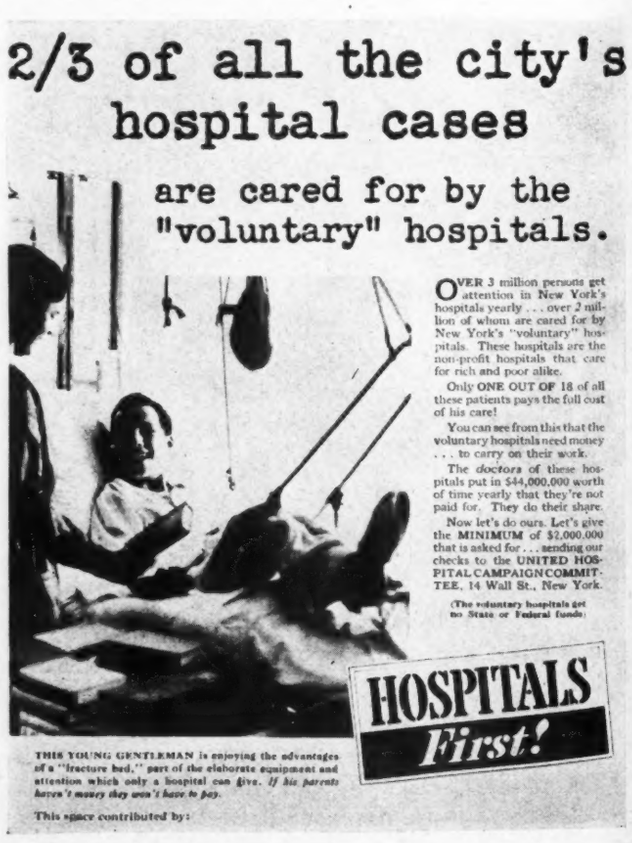
Copy for most of the radio speeches was written in campaign headquarters which enabled us to emphasize phases of hospital service of most interest to the community and also enabled us to guard against misstatements.

Needless to say, none of this radio time was purchased. It was contributed by the broadcasting companies.

On the Air

A few of those who spoke for the campaign on the air were: Mr. Pyle and Myron C. Taylor, chairman of the board of the United States Steel Corporation; Honorable Ogden L. Mills, former secretary of the treasury; Stuart M. Crocker, vice chairman of the campaign and vice president of the International General Electric Company; Mrs. William Armour, chairman of the United Hospital Fund woman's division; Colonel Theodore Roosevelt; Howard S. Cullman, president of Beekman Street Hospital; Dr. Samuel J. Kopetzky, editor of the *New York Medical Week;* Dr. E. M. Bluestone, president of the Hospital Conference of the City of New York; Dr. Shirley Wynne, former health commissioner of the city; Samuel W. Reyburn, president of the Associated Dry Goods Company.

Dr. John H. Finley, associate editor of the *New York Times,* and chairman of the campaign



speakers' bureau enrolled seventy-five speakers who averaged slightly more than one engagement apiece because the motion picture took the place of speakers at many meetings.

Approximately 1,000,000 pieces of printed material, including the usual pamphlets, facts leaflets and workers' kits were used in various ways in the campaign.

The major pamphlet was illustrated with pictures from "Men in White," provided free by the Metro-Goldwyn-Mayer Co. This pamphlet, although it was not used for solicitation purposes, brought in gifts in excess of $40,000.

Cartoonists of the metropolitan dailies were appealed to for cartoons illustrating the campaign. Among those who responded were Kirby of the *World-Telegram,* Harding of the *Evening Journal,* and several others. Captain Bruce Bairnsfather, the English artist who was in town at the beginning of the campaign, contributed a cartoon and James Montgomery Flagg did a poster.

Six illustrated feature stories were written by staff writers for the *World-Telegram* and the *Brooklyn Eagle.*

The *New York Times* magazine section assigned Russell Owen to do a biographical sketch of Mr. McGarrah, which was excellent in that it helped to instill confidence in the committee.

The *Herald-Tribune* ran a special Sunday article in the form of an interview with Mrs. Armour, describing social service work.

Nearly 400 columns of newspaper space was devoted to the campaign. Each day news stories not only on the process of organization but articles on the various phases of hospital service were released to the papers. Two or three times a week, lists of contributors were released and the stories on each new chairman of a trade division were sent to the trade journals.

Governor Herbert H. Lehman, who is highly respected throughout New York State, sent a special letter of endorsement which the papers all published.

Weekly report luncheons were held, each of which was addressed by an outstanding speaker. Among these were Dr. George E. Vincent, chairman of the Hospital Survey for New York, and Thomas E. Dewey, special prosecutor of vice and rackets.

A Dramatic Incident

One of the most dramatic moments at any of the campaign luncheons was staged at Brooklyn's opening meeting in the Hotel St. George. The room was darkened, a spotlight thrown on Alois Havrilla, famous radio announcer, who sat at a microphone broadcasting pertinent facts about the service of the hospitals. As Havrilla finished his part of the program the room was flooded with light and 300 nurses in uniform marched into the room and into the balcony.

To give the idea that the business men of the city were thoroughly behind the hospitals, two public meetings were held at the chamber of commerce of New York State. Dr. S. S. Goldwater, city commissioner of hospitals, spoke at the opening dinner of the campaign and otherwise lent his support.

Fifty-five huge white flags bearing the hospitals' slogans were hung at the entrances of important skyscrapers throughout Manhattan.

As the result of the united front which eighty-one hospitals presented in this campaign, it will be difficult for New York to forget the essential character of the voluntary hospitals.

Curtailing Waste Through Systematic Instruction

How can you expect the cooperation of head nurses in controlling the cost of medical and surgical supplies if the information concerning their cost is safely pigeonholed in the administrator's files? An appreciation of ward costs can only be obtained through a knowledge of the original cost of articles used. The application of business principles is just as essential to successful ward management as the application of nursing principles.

Stimulate a friendly rivalry between the head nurses on the wards through monthly conferences at which time they are given typed reports of the cost of medical and surgical supplies. Break down the cost. Why shouldn't the individual who is to be held responsible for their preservation and conservation know how much gauze, cotton, glassware, rubber goods and instruments cost? Keep monthly comparative figures for study. Why do similar wards vary so much in their costs? Ask the head nurse to explain and justify her mounting costs.

Why not have an annual exhibit of medical and surgical supplies used in the hospital? Prepare it with the costs plainly indicated on each article.

Who checks the breakage? Is it simply exchanged without careful examination? Is not the teaching supervisor the logical individual to check with the storeroom clerk when articles are presented for exchange? It takes but a few minutes and reveals much when supplies are properly exchanged on regular days.

The cost of supplies should not be the secret of the purchasing agents. Enlist the nurses' cooperation by inspiring a sense of responsibility in playing a definite part in the control of medical and surgical costs.—*Edna E. Peterson, principal, school of nursing, St. Louis.*

What Others Are Doing

When It's School Time in the Hospital

There is a room on the top floor of the Mary McClellan Hospital, Cambridge, N. Y., that is quite different from the ordinary hospital room. It is, in fact, first a school room and second, a hospital room. So many were the demands for orthopedic treatment that last year the hospital found it advisable to start a school for handicapped children. The work is under the direct supervision of the local school authorities, but the cost of operation is covered by the additional state aid it receives. So each day a procession of beds and wheel chairs being rolled off the elevator announces school time.

Last year there was a total enrollment of twenty students throughout the year, but never more than ten at a time. This year twenty-six children are already enrolled, representing all grades from the first through high school. With the arrival of a larger group a high school teacher was employed. Some of the pupils are in bed, others in wheel chairs, day beds and at desks. Movable desks and blackboard make it easier for the teacher as well as for the children. This year economics, sophomore English, bookkeeping, commercial arithmetic, introduction to business, agriculture and plane geometry were added to the elementary school courses.

Despite the short hours, two and a half in the morning and two in the afternoon, and the fact that frequent periods of relaxation are necessary, the children are able to keep up with the requirements of the state education department. Last year one child covered two full years of work and another covered all the work of the third year and ten weeks of the fourth.

Staff Conferences Prove Valuable Incentive

For fourteen years, in an effort to stimulate the educational work among its interns and doctors, the staff of the Norwegian-American Hospital of Chicago has held a staff conference every day at 11 a.m., except Sundays and holidays.

Distinguished members of the faculties of Chicago medical schools, hospital interns and staff members and many foreign teachers address these meetings. Leading teachers from the universities at Vienna, Berlin and Lemberg and Lund, Sweden, have given courses. Saturday is intern day and the seven interns rotate in presenting cases. One day a month is a regular staff meeting for the review of hospital cases, reports of departments and the transaction of business.

The effect of this constant educational effort is that the members of the attending and house staffs are kept on their toes, the interns are trained in the organization and presentation of case material, and the younger men on the attending staff are given an opportunity to demonstrate whether they are developing sufficiently to merit their retention. Doctors from neighboring hospitals are invited to hear these lectures and partake in the discussions.

Public Health Program Utilizes Radio

As a part of its public health program, the medical staff of Mount Sinai Hospital, Philadelphia, during the past summer conducted a series of five-minute and ten-minute weekly broadcasts entitled "Your Health and You" which were continued over a period of five weeks.

The broadcasts were made with the full permission of the public relations committee of the Philadelphia County Medical Society, and embodied subjects of interest to the ordinary layman discussed in language easily understandable by him. The subjects included: "Gastro-Intestinal Disturbances Due to Extremes of Temperature"; "Infectious Diseases"; "Prevalent Childhood Diseases"; "Summer Skin Conditions," and "Hay Fever and Asthma."

Copies of the addresses were mailed to listeners upon request following the broadcasts.

Patients Give Impression of Hospital Service

The "Patient's Impression Slip" has proved to be a satisfactory method of obtaining the patient's impression of the service he has received in Toledo Hospital, Toledo, Ohio, according to George W. Wilson, superintendent. At the time the patient is discharged from the hospital, a nurse accompanies him to the cashier's window and after he has paid his account or made satisfactory arrangements for payment, the cashier inquires how the service has been during his stay. Upon this inquiry, the patient usually speaks freely of the service. However, he is not aware of the fact that the statements he makes are recorded on a form for that purpose.

The form used for recording impressions is divided in the following sections: general impression; food service; nursing service; suggestions or criticisms.

There is a space on each form to enter the patient's name, the date of discharge and the number of days in the hospital. After the superintendent has had an opportunity to see the slips, they are filed.

A study has been made of 500 consecutive slips, and under the caption of "General Impression" an attempt has been made to tabulate them. The 500 slips show the following comments: Well satisfied, 284; Wonderful service, 82; Everything fine, 126; Criticisms, 8.

Under the heading of "Food Service" a few complaints were recorded out of this number. When a complaint is made with reference to the food, or any other service for that matter, the person taking the report questions the patient in order to ascertain just what phase of that branch of the service was not satisfactory. With reference to the food, a patient often does not like the kind of food that is served to him even when he is well. Others may feel that the food is not properly prepared. This information makes it possible for the superintendent to investigate the complaint promptly and prevent a recurrence from other patients.

This method of obtaining patients' comments is a helpful factor in the administration of the hospital.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

In Defense of Government Hospitals

By A. C. BACHMEYER, M.D.
Superintendent, University of Chicago Clinics, Chicago

Whether humane, adequate, competent hospital and medical service is provided in government hospitals must remain a responsibility of the general public

IN AN article which appeared in the December 1935, issue of The MODERN HOSPITAL, Dr. Joseph C. Doane asks whether the type of control of government hospitals now commonly observed mitigates against the efficient care of patients?

In the absence of any precise device with which the performance of hospitals can be measured, it is impossible to make definite comparisons. The length of the patient's stay in the hospital has at times been used as an indication of the standard of service. This factor, however, varies so greatly that it is unreliable unless the hospitals under comparison have the same type of service.

We cannot criticize government hospitals as a group because the average length of stay per patient is more than twice as long as that in the voluntary hospitals. Included in the government group are federal and state hospitals whose service is in large part devoted to the care of patients afflicted with illnesses of a chronic nature. In lesser degree the same may be said of county and municipal hospitals.

In these institutions, because of the poor home conditions of many patients, because of the dearth of facilities for the care of convalescent patients and those having illnesses requiring prolonged care, it is often impossible to dismiss patients when the need for intensive and active medical and nursing attention no longer exists. Criticism on this score is often unjustified.

Most government hospitals used as teaching institutions by medical colleges provide a standard of service that compares favorably with that of the voluntary hospitals. In a few the teaching function is carried on under great difficulty because of lack of financial support or more often because of political interference.

While it is difficult to measure accurately the difference in quality of work between the two groups of hospitals, such differences are known to exist. Attempts to answer the criticisms of county, city, or county and city hospitals usually are not successful.

It has been said, for example, that the large size of government hospitals makes it difficult to render a proper standard of service. An examination of the most recent report on "Hospital Service in the United States"[1] supplied the information contained in the accompanying table.

As this table clearly indicates, the average city, county and combined city and county hospital is not of unwieldy size. Except for a comparatively few institutions in large metropolitan centers there are many voluntary hospitals just as large.

GOVERNMENT HOSPITALS

	Federal	*State*	*County*	*City*	*County and City*	*Total*
Number	313	544	496	328	68	1,749
Beds	77,865	473,035	83,919	71,931	11,138	717,888
Bassinets	560	1,154	2,404	3,680	548	8,346
Average Bed Capacity	248.7	867.7	169.1	219.3	163.8	416.1

Even were they larger, the size of city and county hospitals would not be a valid excuse for a poor quality of medical service. Alert attendants imbued with proper ideals can perform their duties in a manner that will assure the relatives and friends of the poorest patient as well as the patient himself that his welfare and personal interests are receiving adequate and proper attention. Earnest, conscientious and competent physicians and nurses have no difficulty in adequately serving patients in the largest hospitals, provided the staff is of sufficient size.

Most criticism is directed toward the county and municipal hospitals. These institutions are constantly and intimately before the eyes of the public. Their patients, employees, nurses and professional staffs are local people and associate with the general public. Experiences and events within

[1] J. A. M. A., 104: 1075, March 30, 1935.

the hospital are frequently discussed. These hospitals, even though their service may be restricted to the indigent, are usually provided to render the community the same type of medical service as that furnished by the voluntary, general hospitals and the performance of the two groups may therefore properly be compared.

City and county hospitals have facilities quite similar to those found in voluntary hospitals. Equipment is usually of the simplest type. A number of our better public institutions, however, have proved that the indigent public do appreciate attractive surroundings and that they respond to a pleasant environment. There is ordinarily less privacy for the patient in the public hospital though in recent years the large open wards have become more or less obsolete.

Doubtless until recently lack of funds has hampered the voluntary hospitals less than the government institutions. But the former, in spite of declining income, have in most instances maintained a proper quality of service while often the government hospitals have not had sufficient appropriations to do so.

This may explain why some of the nonmedical elements of hospital service in government institutions do not measure up to the standards found in voluntary hospitals. The latter cater primarily to the private and part-pay patient and demand a better quality in the nonmedical elements of the service. The government hospitals, serving primarily the indigent group, are not compelled to provide these more expensive elements. It is indeed questionable whether the additional cost could be justified.

The professional service, however, whether the patient be private or free, should be adequate, competent and efficient. Nothing less than this should be tolerated in any hospital.

Equipment Generally Adequate

In general the diagnostic and therapeutic equipment of government hospitals compares favorably with that of our voluntary institutions. There may be some lag in obtaining new devices and apparatus, but a reasonable delay may be proper. Private institutions may well lead the way.

It is not primarily because of facilities or equipment that government hospitals are criticized, but rather because of personal factors.

The "federal" type of municipal government is encountered in most cities in the United States. The mayor, elected by the voters to head the city government, appoints a group of officials as chiefs of the several municipal departments. In the county, in most instances, the three or more men, elected as a board of commissioners, make appointments in much the same manner. The appointed chiefs of departments appoint their subordinates.

Under traditional party political practices the old adage prevails—"To the victor belongs the spoils. " Appointments are made, not upon the basis of fitness, but almost entirely for political reasons. Even when a good man is placed in an important position his appointees are selected for him by the political party and he is hedged about by political restrictions so as to make it difficult for him to conduct his work efficiently. Appointees seldom hold their positions longer than the term of the elected officers. Even when the party remains in power, each change in administrative officers finds many changes among appointed officeholders.

Political Influence Harmful

This system is responsible in large measure for the faults and deficiencies encountered in our government hospitals. It is remarkable that the service rendered is as good as it is for little can be expected when political and personal interests and financial compensation alone are of major concern and qualifications are merely incidental.

Even though a good leader inspires his staff and develops a fairly efficient organization, the fact that their term of employment may be short, contingent upon the election, is reflected in their performance. Under ordinary circumstances two or more months are required to organize a newly constituted staff. Officers in counties and cities are usually elected for only two-year terms; occasionally for four.

Though the active campaigning before an election is limited to one or two months, preelection activities within the political parties begin many months before the active campaign. The attention of appointed employees is diverted from their duties during all of this time as their superiors exhort them to help the party in power. Consequently the service in all of its phases is unfavorably affected. This is bad enough when it involves only the nonprofessional personnel, but unfortunately in many instances physicians and nurses are also involved. Then there is veritable chaos in the institution.

Such political interference is usually the cause of inefficiency and poor standards wherever these are encountered in government institutions. The voluntary hospitals should, however, examine themselves carefully before pointing the finger of scorn at public institutions. Favoritism, intrigue, chicanery and prejudices on a par with civic and party politics at its worst have been known to exist in some of them. When influences of this

type exist the standard of service will suffer. Government hospitals are constantly before the eyes of the public. Therefore, their performance is subjected to more critical examination than is the case with voluntary, nonproprietary institutions which often hide their deficiencies behind the cloak of charity.

Within the last three decades, civil service commissions have been introduced in many communities in an effort to abolish the iniquities of the "spoils" system. The civil service, however, has fallen into disrepute in many places through the manipulations of politicians. Its rules and regulations are disregarded and evaded. Exemptions are freely granted.

Where the civil service operates independently of the political party; where government employees are forbidden to participate in political activity or contribute to political funds; where honest and appropriate examinations are conducted to determine the relative merits of the applicants and where appointments are based upon the results of such examinations, government hospitals can be operated efficiently and the quality of service will compare favorably with the best of the voluntary hospitals.

Undesirable Regulations

In some instances, however, too much dependence is placed upon civil service in an endeavor to avoid all suspicion of political intrigue. Rules and regulations are adopted and enforced that interfere with the administration of the hospital. Regulations concerning residency, promotions, salary increases and the procedures relating to discipline and dismissal often provide obstacles to efficient management.

All the advantages of an efficient civil service system that is flexible enough to permit of the best type of administration can be secured if the hospital is conducted under the supervision of an independent board of trustees. It is important however, that such a board be entirely divorced from all political affiliations. Its members should be chosen from among the best citizens of the community; they should serve without remuneration and have no financial interests of any sort in the hospital's business, and their tenure of office should exceed that of the appointing officer sufficiently to guarantee that no one official or any small set of elective officials can gain domination of the board.

In some communities it has been found advantageous to split up the appointing power among several groups, no one of which can appoint a majority of the board. Such groups may include the mayor and city council, the county commissioners, the judges of the upper courts, the trustees of the local university, if there is one, the school board, and even, occasionally, various civic organizations.

Under such a board one may anticipate that the chief executive officer, the employees and the professional staff of the hospital will be chosen with diligence and because of their qualifications for the positions to which they are appointed.

In a few cities, the municipal hospital and the public health services have been traditionally considered to be nonpolitical activities and there has been no interference in their conduct by politicians. The electorate in such communities would be quick to resent such meddling. In such instances, few in number at present, merit and efficient service are the criteria that guide the selection and motivate the service of the personnel, and the public is assured of competent service of high quality.

Though boards of management of the type previously described are difficult to organize for the control of our state institutions the task is not an impossible one. Here efficient civil service would appear to be the better solution but few of our state systems of civil service can be so designated at present. The task of the state hospitals is a tremendous one. Too much attention has been given to the custodial care of the patient and too little to therapy and rehabilitation. Alert, competent administrators and medical staffs, proficient in the modern procedures of their specialty and huge appropriations are necessary to bring these institutions to the proper plane of performance, though much can be done to improve the quality of the service with the funds now available, as has been shown in a number of instances.

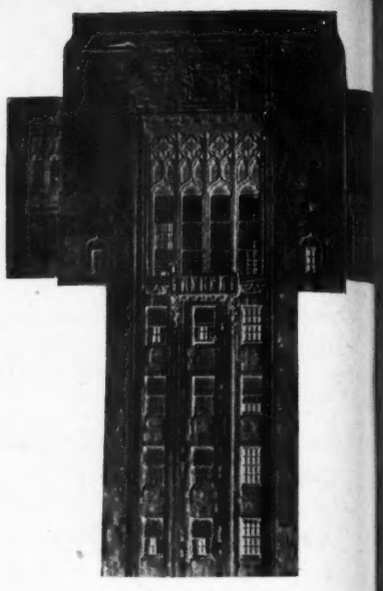
Federal Hospitals Superior

Comparatively little criticism is voiced concerning the federal institutions. There is general acknowledgment of the fact that the quality of their service is superior to that of most state, county and city hospitals. Their control by political parties is more remote. Administrative officials and personnel generally work under assurances of indefinite tenure of office and their attention to their duties is not so readily distracted as is the case in our local hospitals. Their financial support has been more adequate.

Whether humane, adequate, competent hospital and medical service is provided in our government hospitals must remain a responsibility of the public. An interested, alert electorate will see to it, provided it is fully informed of all the significant facts. As administrators it is our job to supply these facts.

Hospital Extension Service Benefits—

the patients the staff men the hospital



By IRVING S. CUTTER, M.D.
Dean, Northwestern University Medical School

PASSAVANT Hospital, Chicago, for the past six years has been offering a form of service not commonly found in hospitals and one which has threefold merit — it is of value to patients, to members of the staff and to the hospital.

When the building was planned in 1928 the idea was conceived of setting aside space on the first floor, adjoining the main lobby, where the physicians and surgeons of the staff could meet their private patients. These men have downtown offices, but as they are obliged to spend considerable time in the hospital it is often a great convenience to have office space available where routine examinations of private patients may be made. The necessary tests and treatment procedures are carried out expeditiously and at one central point.

All Arrangements Made Promptly

This hospital office service has grown rapidly and it is now routinely used by a large proportion of the staff. Furthermore patients come to this department from physicians' private offices with requests that certain examinations be made or treatment plans instituted. This arrangement saves the patient time and effort because all procedures are directed from one central place instead of compelling him to visit several different and possibly widely separated offices.

Private out-patients when they reach the hospital are referred by the admitting clerk to the secretary in charge of the staff offices. Tests are arranged for and all necessary appointments made with other departments in the hospital, the work being expedited as much as possible. The patients are personally escorted to the different departments and introduced to the technician who takes the x-ray picture, who carries out the metabolism test or who gives physiotherapy or other type of treatment. All reports from departments are gathered by the staff office secretary who either delivers them to the referring physician personally or mails them to his office. The bill is paid by the patient at the time or is sent to his home.

That the arrangement has appealed to patients as well as to the staff is shown by the fact that many persons prefer to consult physicians at the hospital instead of at downtown offices. Fortunately Passavant is located near a large residential section of the city in a quiet neighborhood where there are ample parking facilities.

The space utilized for this extension service is divided into twelve rooms equipped for carrying out various types of examinations. Nine of them are used interchangeably for postoperative patients — the renewal of surgical dressings, for gynecologic patients and for medical examinations. One is especially equipped as a clinical laboratory, one for ear, nose and throat work and one for eye patients. No charge is made to staff members or patients for the use of these rooms. The income is derived wholly from laboratory and technical services for which the patient pays.

Net Profit Is Substantial

The expense to the hospital consists in the upkeep of the space, the salaries of a laboratory technician and a nurse, and the cost of supplies and dressings. In 1935 nearly sixteen thousand private out-patient visits were handled through these offices and the net profit to the hospital was a substantial figure — sufficient to convert what would otherwise have been an operating deficit into a substantial balance.

The hospital gains indirectly from the work of the department because it has become known to a wide circle of citizens who appreciate not only the accurate service rendered, but the time saved. Many of them think of all medical needs as centering in the hospital.

Health Insurance Invades the Northwest

By JAMES M. COADY
Chairman, Legislative Committee, British Columbia Hospitals Association

Alberta and British Columbia, Canada's western provinces, are about to try health insurance after several years of extensive inquiry. Working apart, each province has developed its own plan, differing drastically from that adopted by the other

WHETHER we approve or disapprove the principle of health insurance, we must face the definite consideration that the public is demanding some such legislation today to safeguard them against the exigencies of medical and hospital costs.

The time has come when hospitals must give serious study and consideration to any proposed plan of state health insurance. Any such plan is bound to affect them. The hospitals, therefore, should and must be of constructive assistance in molding legislative action.

The essential element of any scheme is that it be financially sound. Most hospitals have been for some years carrying on under severe handicaps and are only able to survive by aid of the government and municipal grants and private donations. The latter are very small, but the provincial and municipal grants, varying in the different provinces according to governing provincial legislation, provide a support which is absolutely necessary.

It cannot be seriously contended that the hospitals are operating extravagantly. The general opinion of hospital administrators today is that the cost of administration is increasing. Any system of state health insurance, therefore, must be predicated upon the assumption that the present operating costs of hospitals are not likely to be reduced, and that, under any plan of health insurance, a sufficient amount must be set aside to provide for the hospitalization of those coming under the scheme. Otherwise the deficiency must be made up, as heretofore, from the provincial treasury and the municipalities.

It is of interest therefore to review in a general way the two types of state health insurance now presented in the two western provinces of Canada —British Columbia and Alberta—the former being a suggested plan in outline, and the latter, recently enacted, to be worked out experimentally in a certain district and then extended throughout the province.

The British Columbia Plan

In British Columbia a state health insurance commission was appointed some years ago, and after extensive inquiry and investigation made its final report in 1932 and indicated in this that the members of the commission are definitely in favor of the early establishment of a system of state health insurance. The report says:

"Finally we would say that our recommendations for the early establishment in British Columbia of a suitable compulsory health insurance plan, including maternity benefits, are the result of the members of our commission having become thoroughly imbued with the momentous and incalculable beneficial effects which kindred schemes in the old world are producing in alleviating for the poorer classes the dread incubus of sickness costs, and thereby reducing premature mortality and raising the general standard of health among the masses."

The department of the provincial secretary of British Columbia has since that time continued its investigation into this question and this year prepared a draft bill of a comprehensive system for the province. This was submitted by the provincial secretary to the members of the legislature at the last session, with an explanatory memorandum for the consideration of the members of the legislature and for study and consideration by the general public and the particular groups most directly concerned.

The cost, it is estimated, would be about seven million dollars annually. The provisions of the bill can easily be extended to include probably 90 per cent of the population in time, and if so, the cost would probably amount to nine or ten million dollars. It includes medical, nursing, dental, hospital and pharmaceutical care with a provision

likewise for certain limited cash benefits for the wage-earner during periods of disability. The bill is compulsory to the extent that it includes all wage-earners earning $200 a month or less, and all indigents for whom the provincial government assumes the cost. There is an optional feature for voluntary admission and contributions from those who may be in receipt of salary or income in excess of $200 a month; also for residents of rural districts including organized municipalities, who may wish to come under the act by a vote of the municipal electors.

Furthermore, while the bill is comprehensive in its scope, all the various benefits will not be granted at the inception, but such extensions may be granted from time to time as the health insurance commission may decide, with the approval of the lieutenant governor in council. However, with the plan fully in operation, it is expected that practically all wage-earners and all indigent persons will be covered.

Bill Designed to Be Flexible

In a word, the bill as drafted is designed to be flexible and adjustable and capable of development and growth as experience and changing conditions indicate modification. The provincial authorities have made an exhaustive study of the subject of state health insurance in its application to the conditions peculiar to British Columbia. As the explanatory memorandum says:

"Firsthand advice has been obtained from Canadian, British and American experts in hospital insurance as well as from the social insurance section of the International Labor Office in Geneva. Leading Canadian actuaries and statisticians have prepared and checked calculations on probable costs and medical advice has been obtained from the committee on economics of the Canadian Medical Association as well as from prominent members of the medical profession of the province. In addition, the work of the British Columbia Royal Commission on Hospital Insurance has proven most valuable to the formulation of the bill."

A committee of the British Columbia Hospitals Association has had under consideration for some time the plan as proposed. Its object was largely to ascertain how the proposed plan would affect the hospitals, particularly from a financial standpoint.

Under the plan, the hospital cost is based upon public ward rates, but the scheme does not provide for all necessary hospitalization. It only provides for full and complete hospitalization for twenty-one days; for further ward care, not exceeding ten weeks, the commission shall not pay more than three-fourths of the cost of hospital care; there is no provision for hospitalization beyond that period. The hospitalization of indigents is to be paid for at one-half the regular cost to others. It is felt that these are decided weaknesses in the proposed legislation. It only means that the deficit in hospital cost must be made up from other sources—principally provincial and municipal grants.

Some patients coming under the scheme will require some better accommodation than public wards and will be given that accommodation providing they can pay for it. The amount, however, to be collected in this connection is problematical and it is doubtful what percentage will require this additional service.

The British Columbia plan adopts many of the recommendations found in the report of the committee on economics of the Canadian Medical Association. The proposed bill provides for contribution by the wage-earner of 3 per cent of his salary. A man earning $2,000 a year therefore pays for himself and his dependents a contribution double the amount paid by a man earning $1,000. The benefits to which they are entitled under the proposed legislation are the same. However, this is probably a sound principle of taxation, for the greater load is carried by the man who is in the better position to pay.

Hospital service under the British Columbia proposal includes all the usual services which the hospital is equipped to provide as required by the attending general medical practitioner or specialist, but does not include services of medical practitioners, private duty nurses and laboratories. It would appear, too, that under the proposal, the hospitals would be paid for drugs and medicines supplied. It would appear further that x-ray and operating room charges are included in general hospital services that must be supplied.

Increasing Demand for Services Expected

The committee of the British Columbia Hospitals Association is of the opinion that (1) somewhat restricted hospital service, as provided for under the proposed legislation as to time, is not satisfactory, (2) the estimated cost of hospitalization under the scheme is inadequate and (3) with the inclusion of the x-ray and operating room costs in the general per diem allowance, the allowance is not satisfactory. They feel that these latter charges should be paid for in addition to the per diem ward rate, or, if included in the per diem ward rate, this rate should be generous enough to safeguard the hospitals. They feel, too, that there will be a decided increase in the demands for these services, which will increase costs.

The British Columbia proposal, it is estimated, will embrace about 500,000 of the population, leaving approximately 200,000 uncovered, with provision, however, for those 200,000, or most of them, to come under the act as it may be extended. The wage-earners and their dependents, it is estimated, will number about 400,000; the number of indigents, approximately 100,000.

Provision is made also under the British Columbia plan to empower the committee to work out, with and for the hospitals, schemes of voluntary hospital insurance to which any person irrespective of income may belong. This is an important feature in British Columbia where there are now in operation a number of voluntary schemes of group hospitalization, some in industrial centers and others in farming communities. Whether these will be absorbed in their entirety or permitted to function on a voluntary basis when the act comes into operation, remains to be seen.

Per Capita Service Estimated at $3.50

The amount estimated to take care of the hospitalization is $1,575,000. Per capita hospital service covering all insured is estimated at $3.50, with provision for an increase to $4. The wage-earners and dependents, it is estimated, will number 400,000. With the per capita allowance of $3.50, this makes a sum of $1,400,000. One hundred thousand indigents at one-half the regular hospital capita, namely, $1.75, means an additional $175,000. This makes the estimated total of $1,575,000.

There is a provision in the proposal for the appointment of a hospital committee to advise the commission on matters pertaining to hospitals, and the commission shall have power after obtaining the advice of the hospital committee: (a) to define the nature and the extent of the hospital care to be provided and the manner of the provision; (b) to designate hospitals for the treatment of insured persons and to require such hospitals to maintain reasonable standards of service; (c) to control hospital admissions and discharges of insured persons; (d) to provide for the payment of hospitals serving insured persons; (e) to deal with all other matters which have to do with the provision of hospital benefits.

There is likewise provision for similar medical, dental, nursing and pharmaceutical committees.

It has been extremely difficult to arrive at any definite conclusions with respect to working out the proposed plan. Unless the estimated cost of hospitalization under the plan is considerably increased, it would appear as though the provincial and municipal grants will have to be continued for some time.

A committee has been appointed by the government to receive the comments, opinions and criticisms of the proposed legislation, with a view to having it remodeled in such a way as to ensure the adoption of a financially sound and workable plan.

Changes in Bill Recommended

Since this article was first drafted the report of this committee has been published. It recommends several changes which will overcome objections in the draft bill previously published. The recommended changes of particular interest to hospitals are as follows:

1. Hospital ward care should be provided for a minimum of three weeks without charge to the patient or for a longer period if financially feasible.

2. Cash benefits should not be included at the beginning benefit but the commission should be instructed to study the question with a view to their introduction when feasible.

3. The services of osteopaths and chiropractors should not be included.

4. The insured persons, whether coming in by legal compulsion or voluntarily, should be limited to those with incomes under $150 a month instead of $200 (except that members of existing private plans that are taken into the provincial plan should not be excluded because of income).

5. The health insurance commission should be empowered to make satisfactory provision for the medical care of indigents and financial responsibility for this service should be entirely assumed by the provincial government. In view of the opposition to the principle of half-pay for indigents, the committee recommends that this be deleted in the revised bill.

6. The principle of free choice of physicians by indigents should be modified insofar as is necessary to avoid interference with the rights of hospital boards to select and control their medical staffs.

7. The definition of "dependent" should be more carefully restricted and also the definition of "indigent." It is suggested that indigents be limited to those actually dependent for their support on public funds.

8. The British Columbia Hospital Act should be revised in the light of the changed financial picture of the hospitals resulting from health insurance. The ultimate responsibility of the province and municipalities for the continued operation of hospitals must be recognized.

9. The rather complicated group of committees set up in the draft bill should be eliminated and the health insurance commission of three, four or five members and a small technical advisory com-

mittee of not over six members provided in the bill. The commission should then have power to create such additional committees or councils, provincial and local, as are necessary.

10. The health insurance commission and not the advisory council should have power to determine whether an existing private health insurance plan should be brought under the operation of the act.

11. Adequate medical care should be provided through the provincial board of health to all children not eligible for health insurance benefits.

The hearings committee was under the chairmanship of Allon Peebles, Ph.D., adviser on health insurance of the provincial secretary. E. W. Neel, president, British Columbia Hospitals Association and Grace Fairley, superintendent of nurses, Vancouver General Hospital, were members of the committee. Dr. Alfred K. Haywood, superintendent, Vancouver General Hospital, was a consultant to the committee.

The Alberta Plan

The Alberta act, passed in 1935, differs rather drastically from the British Columbia proposal. Under it, the employee contributes five-ninths of the cost; the employer, two-ninths, and the state, two-ninths. Where the income earner is engaged in business for himself in private industry or otherwise, the individual income earner contributes seven-ninths. The cost of the care of indigents is a charge upon the collective funds and included in the budget.

The act provides for the establishment of medical districts, and it is planned to establish one or two, including a number of municipalities, both rural and urban, where the act may be put in operation, and then gradually to extend its activities until in time it will cover most or all of the province.

Under the Alberta act, every resident of a medical district shall be entitled to receive, without charge, the following benefits: (a) any necessary hospitalization in a public ward; (b) any necessary nursing services; (c) any necessary medical, surgical and dental attention, advice and treatment; (d) the benefit of such laboratory services, as x-ray and biochemical services, and such hospital facilities as may be requisite for the purpose of diagnosis; (e) all such drugs, medical and surgical supplies and appliances as may be prescribed by the medical practitioner under whose care he is for the time being.

The act differs from the British Columbia proposal inasmuch as it covers all necessary hospitalization without any restriction whatsoever, and the amount collected is based upon this and thought to be sufficient to cover the full hospitalization cost.

Under the Alberta act every municipality included in a medical district pays annually $11.28 for each resident in the municipality or in the part of the municipality coming under the scheme. This is equivalent to seven-ninths of the cost and constitutes the full source of income for the health insurance commission established under the act. No payments are made by the individual direct to the commission; the municipality collects these. Every person who is employed at a salary or wages, and is a resident of a medical district, shall pay to the municipality in which he resides, a monthly sum of $2.01. Every employer of any person at salary or wages who is a resident of a medical district, shall pay to the municipality in which the employee resides a monthly sum of eighty-one cents for each person so employed.

Every person who casually employs any person who is a resident of a medical district shall pay monthly to the municipality in which the employee resides, the sum of one-half cent for every hour during which any such person has been employed by him. Every person who is a resident of a medical district who is casually employed shall pay to the municipality in which he resides a monthly sum of one cent per hour for every hour during which he is so employed.

Every income earner of every description other than wage earner, who is a resident of a medical district shall pay to the municipality in which he resides annually the sum of $33.83 or $2.82 per month.

A Census Should Be Taken

There is provision for local advisory boards for each municipality included in the medical district, and further, there is provision that upon the constitution of any medical district, every municipality, wholly or partially included therein, shall proceed as soon as possible to take a census of all persons whatsoever in the municipality or the part thereof included within the medical district and, in taking the census, shall ascertain whether or not the persons included therein are residents and income earners or likely to become income earners.

The amounts payable by the municipalities and by the wage-earners and employers or income earners are based upon the report of the Alberta legislative commission and statistical information which it has compiled, all of which is well worth investigation. Here again experience in operation will be the test, for doubts have been expressed concerning the applicability of certain actuarial data. It will be noticed that the act applies to all

wage-earners or income earners. The amount payable by each wage-earner is a definite fixed sum, irrespective of the income which he receives.

In the statistics on which the Alberta plan is based, hospital costs have been established on a basis of operation, capital and reserve charges. This is not so under the plan to be tried in British Columbia.

Under the Alberta act, it is calculated there is one wage-earner to each unit of three persons. The British Columbia act basis is one wage-earner to each unit of 2.25.

If the hospitals are to be definitely assured of payment at a proper rate from all coming under the scheme, this should be more satisfactory and less uncertain than the doubtful right of collection. The plan is intended to relieve, eventually if not immediately, the provinces and municipalities from the payment of grants.

The statistics on which the estimated costs of both schemes are based, are extremely interesting. There is a generous allowance for all unforeseen contingencies, yet it is quite impossible to say how it will work out. If the province has calculated incorrectly, this certainly must be made up to the hospitals.

The hospital is in an entirely different position in this regard from the medical and nursing professions. The hospital is supplying a service that demands a heavy capital outlay and if it is to continue in operation it must so operate as to provide a sufficient margin to allow for repairs, replacements, extension of service and interest charges.

In both the Alberta and the British Columbia plans, the patient is given free choice of doctors. This will no doubt be insistently demanded by the public. The question, therefore, arises as to how this is going to affect the "closed" hospital. There has been no difficulty where the patient is not a paying patient. If the patient comes under the scheme, however, he is then a paying patient, although indirectly. This is worthy of consideration.

Under any scheme of health insurance we may reasonably expect an increase in hospitalization. This, too, will require in many cases additional hospital accommodations and facilities. The Royal Commission of the Province of British Columbia estimated that the increase would be about 10 per cent. The legislative commission of the Province of Alberta reported similarly. Some hospital executives estimate this as too low.

It has been suggested that with a commission charged with the administration of state health insurance, more economies and a more complete service may be demanded. All duplications will have to go; overhead, if possible, will have to be reduced. There will, in a word, be a more strict supervision of the operation of hospitals. It may mean eventually that every extension of service, including building programs, will have to receive the approval of the commission. It will probably mean, too, a demand for much closer cooperation between the hospitals — particularly when several hospitals are established in one community. It may easily lead to encroachments upon the field of service now covered by the boards of hospitals — citizens who join in giving their time and service to the interests of the public without remuneration. It will probably, too, affect donations to hospitals or private philanthropy. If the state or any department of the state under a system of health insurance assumes control and direction generally of the hospitals, it is felt that private philanthropy will be discouraged.[1]

[1]Prepared for the Canadian Hospital Council's committee on hospital finance under the chairmanship of R. Fraser Armstrong, superintendent, Kingston General Hospital, Kingston, Ont.

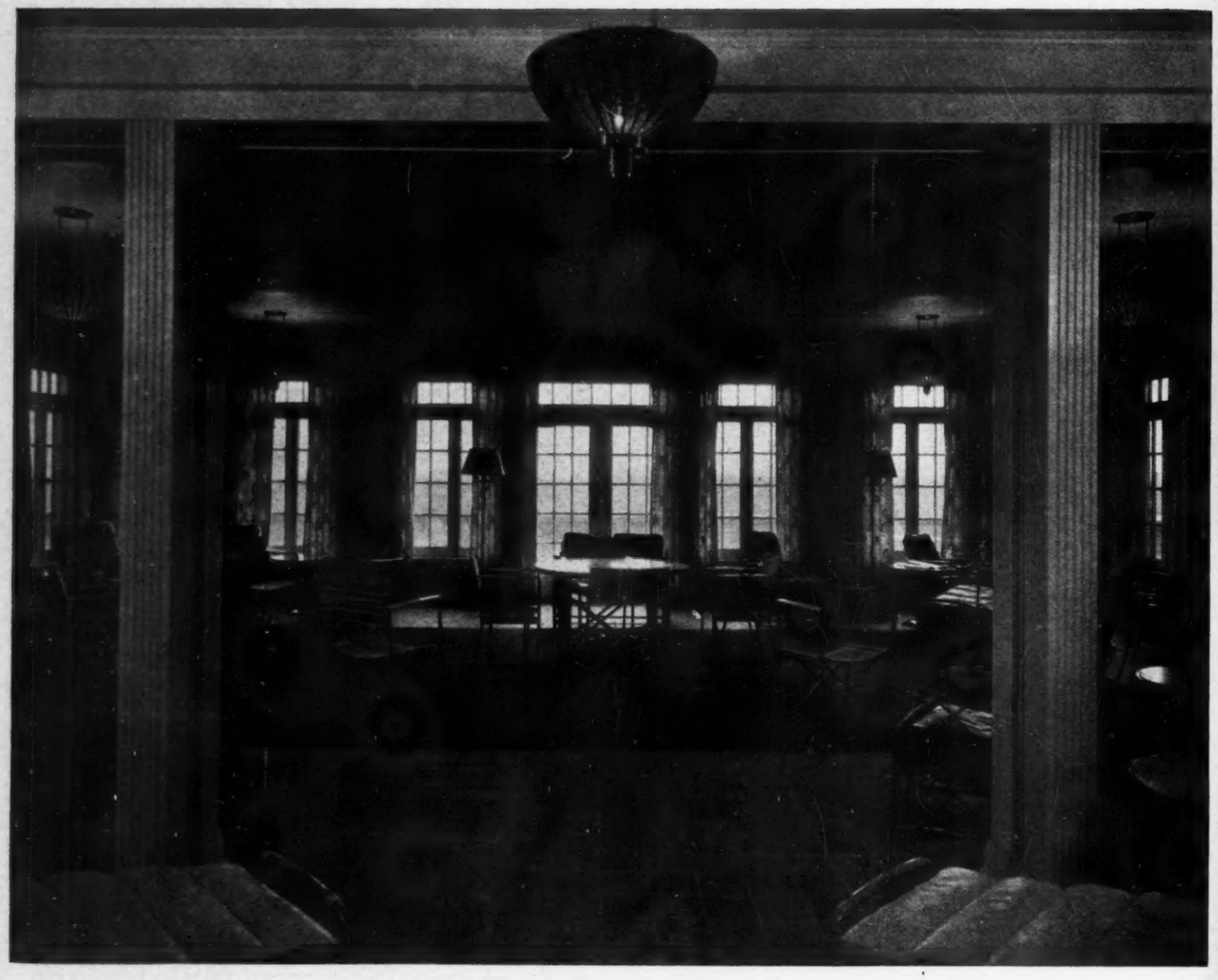
Sound the Alarm First

"When shall I ring the fire alarm?" asks a nurse who has learned to be considerate of her co-workers. "Shall I try to put out the fire or locate the smoke myself, or sound the alarm anyway while doing something about it?" The engineering department is one of the busiest departments of the hospital and should, of course, be spared as many adventures of this kind as possible. The inquiring nurse bears this in mind when she asks her question.

The best time to sound an alarm coincides with the time when the cause for the alarm is discovered. The time element is of major importance here, as it is elsewhere in emergencies. The instructions should therefore be "Play safe—always give your patients the benefit of any possible doubt—don't take chances—never mind rules in emergencies—use your head and you won't jeopardize your standing with your superiors. You may, indeed, improve it."

During a period of emergency all rules and regulations are suspended and the autocrat of the superintendent's office directs his crew spontaneously and in accordance with his best judgment at the moment, hoping only that they will respond intelligently.

The administrator of a large hospital in the East reports, apropos of this, that his working staff exhibited great ingenuity, and thereby helped him considerably, when the entire basement of his hospital was under water, as a result of the bursting of a water main in the street outside of his hospital on a bitter cold day last winter. Rules and regulations could not govern such a situation and the administrator was lucky to have a crew who did not have to wait for his orders to set things right. They used their heads in an emergency.—*E. M. Bluestone, M.D., Montefiore Hospital, New York City.*



Nurses at Cook County Have a Homelike Home

By

MARGARET R. GRIFFIN, R.N.

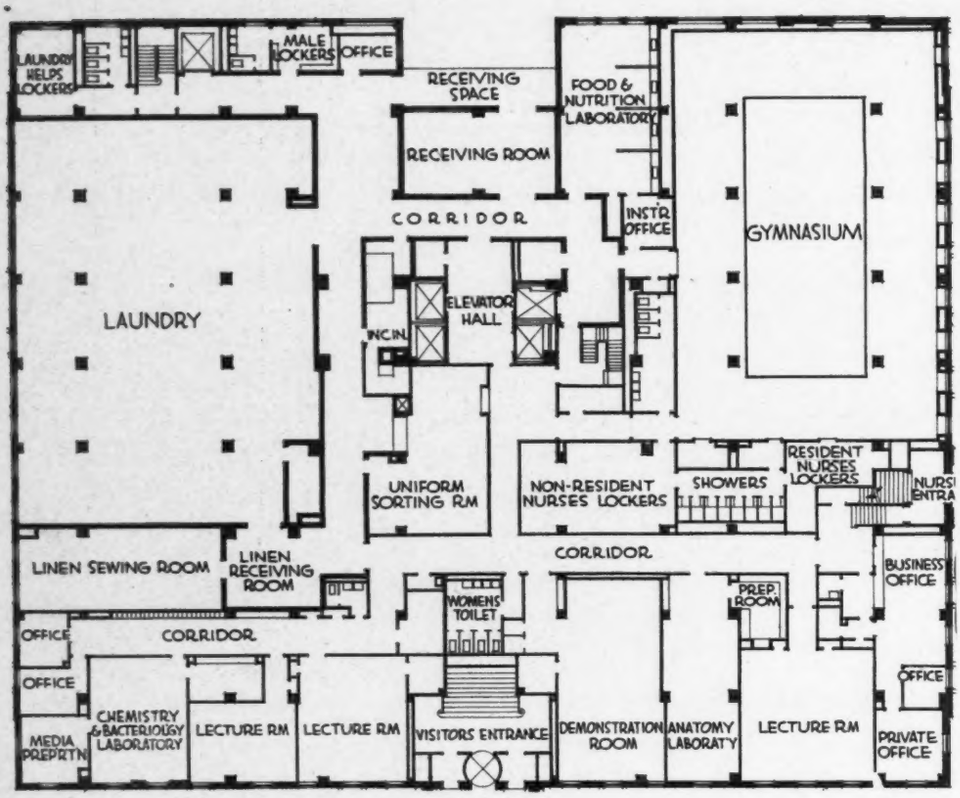
Instructor, Cook County School of Nursing, Chicago

DURING the second week of May, 1935, the Cook County School of Nursing, Chicago, moved its personnel into a new building which combines the most recent and best ideas in living quarters and educational and recreational facilities.

The building and its equipment are the product of collaboration between government agencies and private individuals comprising a citizens' advisory committee who have a lively and disinterested concern for public welfare. Persons concerned with the administration and educational program of the school and home were frequently consulted in regard to architectural features and specifications for equipment. The architects in consultation with subcommittees of the large citizens' advisory committee concerned with decoration and furnishings, kitchen and laundry equipment and library, recreation, classroom and laboratory facilities, drew up detailed specifications which were presented for competitive bids.

Funds for the completion of the building were

In the students' lounge (below) red is the color motif and a pastoral mural is on the north wall. Above are shown the library and the gymnasium. On the opposite page appears the solarium with its French doors.



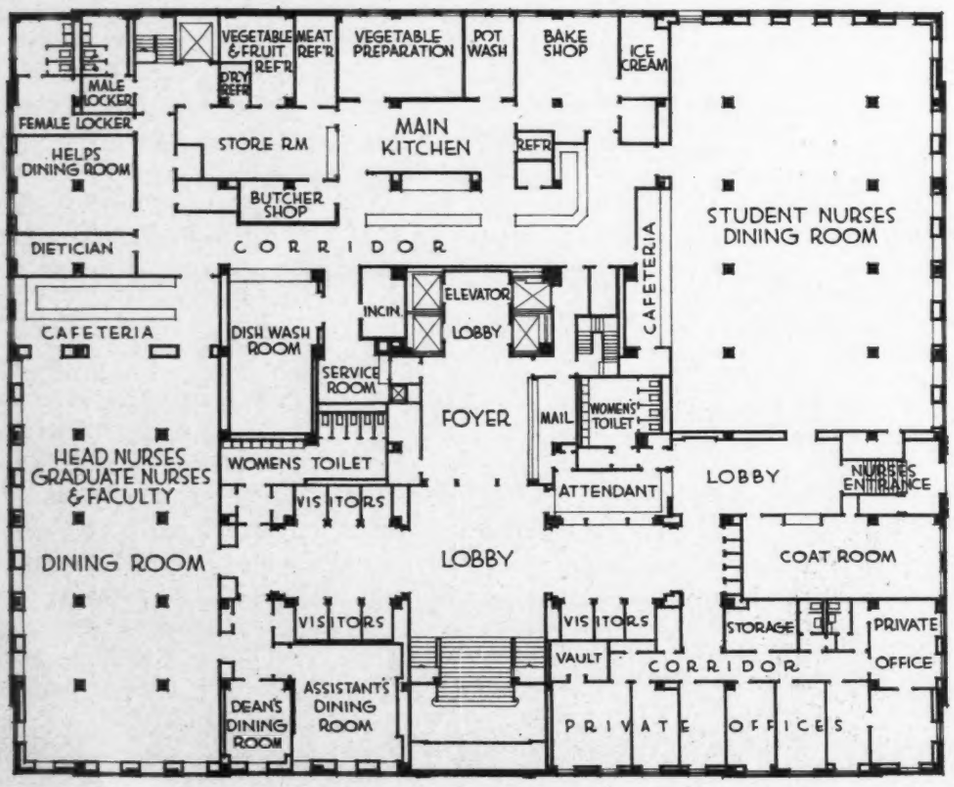
On the ground floor are three classrooms with a combined seating capacity of about 140. Here also are three laboratories. The gymnasium is on this floor.

obtained by a loan through the Reconstruction Finance Corporation. Final authorization for expenditures for this building, known as "Federal Emergency Administration of Public Works, Project No. 790," was given by the federal representative of the PWA in Illinois. The time and effort given by the citizens' committee are largely responsible for the pleasant homelike atmosphere of simplicity and good taste characteristic of the furnishing and decoration of the building.

The framed paintings, woodcuts and water colors and the two mural paintings that add greatly to the charm and dignity of the public rooms, were secured for this building by the federal government under the Public Works of Art Project.

Most of the basement, ground, first and second floors and all toilet rooms without outside windows are specially ventilated. Air is exhausted from the rooms and filtered, tempered air is supplied to them. The floors so ventilated and the entire infirmary floor have automatic thermostatic controls on the radiators. All water entering the building is filtered. City water pressure supplies basement, ground and first floors and the second to sixteenth floors inclusive are fed from a roof tank. Water is heated in closed heaters in the engine room controlled automatically by thermostats.

All sewage from the first floor up flows to city sewers by gravity. Sewage from the ground and basement floors is removed by ejector pumps in the engine room. Refrigeration is by carbon dioxide compression.

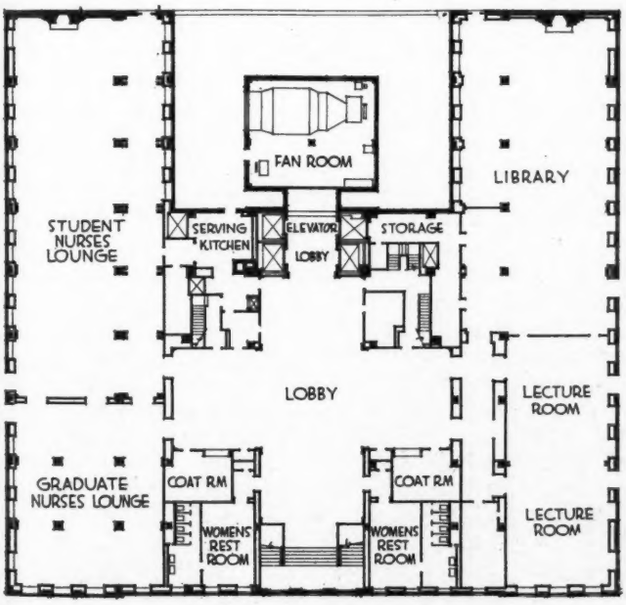


The kitchen and the two dining rooms are on the first floor and are so arranged that the modernly equipped kitchen opens directly into the serving room of each.

Brine is cooled in the engine room and circulated from first to sixteenth floors inclusive. All kitchen ice boxes are under thermostatic control. There is a destructor incinerator for general refuse and garbage and a house incinerator with chutes on each floor which dump directly into it. The call system consists of a buzzer to each room and a return buzzer and light to the switchboard operator.

The classrooms and laboratories are on two floors. On the ground floor are three classrooms with a combined seating capacity of about one hundred forty. Here also are the three laboratories, the demonstration room and the gymnasium. One laboratory is designed and equipped for teaching anatomy and physiology and another for bacteriology, chemistry and pharmacology. The third laboratory, for foods and nutrition classes, includes four complete units for food preparation.

Construction of a swimming pool was halted after excavation and the space was floored for use as a gymnasium and game room. Formal classes in physical education and group games are held here under the direction of a qualified instructor. The assembly hall of the second floor seats 180 and can be divided into two separate rooms by means of folding doors. This largest of the classrooms is fitted with an acoustically treated ceiling. The corridor on the ground floor along which most of the classrooms and laboratories are arranged contains set-in lockers for students and several closets for classroom supplies, in addition to the closets and cupboards in each of the classrooms and laboratories.



The second floor plan.

The large number of students enrolled in this school, including affiliated and postgraduate students, requires a considerable number of teachers who occupy twelve offices with two or more persons to an office, on the ground, first and second floors. These rooms are provided with desks, chairs, bookcases and file cases so that each instructor has a permanent and convenient place for work.

Two large lounges with west and southwest exposures are on the second floor. The smaller of the two, furnished simply and comfortably for the graduate staff, repeats the sedate blue color of its rug in drapes, pictures and occasional chairs and sofas. Adjoining this room and incompletely separated from it is the students' lounge, at once the largest and most colorful of the lounges. The dominance of red in its color motif is softened by the delicate greens and blues of the pastoral mural on the north wall. Both these rooms have outside balconies along the west wall. The third lounge, reserved for the administrative and

teaching staff is a small one on the first floor conveniently near the dining room.

Across the foyer from the large lounges is the library, a room that will seat two hundred at long tables and fifty at tables in the alcoves between the stacks. The wall trimmings, shelves and furniture are of dark wood in sixteenth century English style. The floor is covered with rubber tile in brown and tan tones. In this room are hung water colors and xylographs illustrating events in the history of Illinois and in the life of Abraham Lincoln. The library has a balcony that opens through French windows and is continuous with the balcony along the assembly hall.

The second floor foyer itself is deserving of special mention. Because of its spaciousness, graceful design, proximity to the lounges and main stairway and its connecting service pantry it will be useful in many social functions. A great deal of its charm is due to a mural painting on the north wall done in the incisive modern manner, imaginative in subject and somberly brilliant in color.

Ample Equipment for Food Service

The kitchen and the two dining rooms on the first floor are arranged so that the kitchen opens directly into the serving room of each. The kitchen is spacious, well supplied with daylight and completely and modernly equipped. The food storeroom contains three large refrigerators where meats, vegetables and dairy products are refrigerated separately. Smaller ice boxes elsewhere in the kitchen accommodate a day's supply of those foods that require refrigeration. The vegetable preparation room has its own refrigerators and steam cookers. The bakery has electric ovens and proof box and a refrigerator for puddings and confections. Adjoining the bakery is a small room equipped for making ice cream.

There are five gas ranges and as many gas ovens, and a special room for washing trays, silver, glass and china ware. The large serving rooms in the dining room are designed for cafeteria service with steam tables, refrigerators, coffee urns and a large amount of counter and shelf space. The combined capacity of the students' and graduates' dining rooms is over five hundred. Most of the tables seat four and the remainder seat six each. Both rooms have wood paneled pillars and acoustically treated ceilings.

The third floor is a bedroom floor. It differs from a typical floor in that it contains a large solarium furnished with stick willow sofas and lounging chairs, glass topped tables and colorful chintz drapes. A large tiled roof space surrounds the solarium on three sides and offers pleasant opportunity for sunny and open air repose in canvas and metal chairs.

Typical bedroom floors continue from the third to the fifteenth floor. Each floor has sixty-nine sleeping rooms, eight pairs of which have connecting baths, two common bath and toilet rooms with both showers and tubs, a small sitting room with connecting kitchenette, a combination laundryette and ironing room and four public and two house telephones in single booths. The total number of sleeping rooms is 821; most of these face east or west, some south and all have unobstructed daylight.

Typical rooms are furnished in maple, including a bed, desk with bookshelves, straight backed chair, dresser with separate mirror, lounging chair and end table. Each has a light fixture on one wall, a floor lamp and a desk lamp. All bedrooms except those with connecting baths have small lavatories and cabinet mirrors. Cooled water is piped to drinking fountains on all floors.

The fifteenth floor is set in, and is smaller than the typical bedroom floors. It comprises a well equipped infirmary of twenty-eight beds. The length of the infirmary runs east and west and at each end is a solarium and a sun roof which will be used for sun bathing by the students and graduate staff as well as the convalescent nurses in the infirmary.

The improvement in living conditions for nurses in one of the world's largest charity hospitals made possible by this building will unquestionably raise the general health level of the nursing staff and increase its efficiency and value to the hospital.

Is the Right of Selection Unlimited?

The voluntary hospital, which is the philanthropist's gift to the community, enjoys, among other things, the legal right of selection of its clinical material, while the public hospital must accept anyone who seeks relief, including patients transferred from voluntary institutions for any cause whatsoever.

This is one of the reasons why the voluntary hospital is considered "the gentleman of the hospitals" and the "pacemaker" and "civilizer" among institutions. In selecting the "interesting" case the voluntary hospital is in a position to develop a scientific staff, working on a voluntary basis, as productive as it is philanthropic. There is much to be said for this legal right of selection.

However, what about the moral aspect of the situation? What does it profit us in the end if the right is conferred on a young ambulance surgeon, in training, to bring certain patients back with him, while giving others the "ship-it-to-Bellevue" treatment no matter how sick they may be?

Condescending Staff Men

By E. M. BLUESTONE, M.D.
Director, Montefiore Hospital, New York City

IN DISCUSSING the question of the hospital and the practitioner, let us single out from the general group of medical men for special emphasis those practitioners who are "outsiders," as far as hospitals generally are concerned. A vicious circle is at once brought into view. Presumably one of the chief reasons why the practitioner is an outsider, left to his own devices, is that he does not measure up to the scientific requirements of the modern hospital, to which he often sends his patients when he can no longer, with his own limited resources, deal with them in the patients' homes. At least, most of us hope that this is one of the controlling reasons. We thus have a class problem in the profession, with the intellectuals as the patricians and the practitioners as the plebeians.

On the one hand we have within the hospital a superior group whom we encourage to adopt a condescending attitude toward the practitioner whom we neglect. The group outside of the hospital are stamped as inferior by our negative attitude toward them. The vicious circle begins at this point. The practitioner, disregarded, misses the most valuable stimulus to progress in his profession, and eventually falls into habits that might have been acceptable at the outset of his career but which in the natural course of things scientific become in a very considerable part obsolete.

The estrangement between the practitioner and the hospital which has passed him by, in emphasizing its favors to his scientific superiors, is often provocative of all kinds of evil

The legal right of the physician to practice medicine is never again questioned unless he can be condemned for malpractice — a weapon not often held over his head but of tremendous legal and moral power. If the practitioner considers the competitive public and private agencies a menace that threatens to overwhelm him, he has usually not given much thought to his own professional qualifications. The fault is, however, really only partly his. The more the practitioner is disregarded, the more damage is done to him as a public servant. With the possibility of malpractice and the actuality of economic handicap staring him in the face, it will be seen that our average practitioner is in a fair way to be ground between two millstones.

The first question to be answered is whether or not we want a freely moving body of physicians in our midst to serve the community on a selective and confidential basis. Is the practitioner fulfilling his mission and, if so, how shall we save him from the double menace which threatens his very existence? If not, how shall we liquidate him and his group and on what plan shall we replace him?

Even if the more advanced schools of political economy are right and one menace to his survival may be removed — that of economic insecurity — how shall we meet the other? The two are, indeed, interdependent. The proof of it is that one of the reasons why a patient seeks dispensary care is that he is able to obtain more varied and more highly specialized doctors to attend him, with those facilities at their disposal that a scientific institution freely provides. The question of a fee is not always the controlling factor in the patient's choice of a medical adviser. Most people do, in fact, value their health above money.

Even if we should adopt the extreme tenets of the communist system and nationalize the practitioner, so that money will have nothing whatever to do with his work, how should we preserve for him and for those who depend on him the scientific and humanitarian enthusiasm which brought him into the medical world in the first place? Of the two difficulties in which medical practice finds itself, the professional one is more important to the community than the economic.

A hospital is a public health institution to which the sick are sent who cannot, for social or medical reasons, be cared for adequately in their homes. Whether the sick pay for hospital service

or not, does not in any way alter the definition.

In the present state of hospital organization the best medical minds in the community are selected to deal with the essential functions of the hospital. We hope, at least, that the best are impartially chosen. This is as it should be. The born physician, who becomes richer in wisdom with experience at the bedside, the highgrade clinician, the born teacher and the born investigator are not often one and the same man. Each one has his place and deserves recognition and encouragement commensurate with his talents. Rarely, one finds these talents combined in one individual.

We Must Be Fair

We must accept the fact that, do what we may, the first type, the practitioner, will be in the majority and will always be among us. Our precautions in educating him and licensing him to practice medicine will not be enough if we pass him by after that and leave him to draw his living in a highly commercialized and unfairly competitive environment, without some provision for his continued education in a medical world that is constantly changing.

What are the avenues of escape? At the crossroads, the physician inside of the hospital, who continues the care of the patient, and the physician outside of the hospital, who referred the patient to him, meet. Will they continue on together or will each go his separate way, leaving the one to guess the previous history of the patient, which only the other could have furnished, and leaving the other in ignorance of the natural history of the later phases of the illness for which his patient required hospitalization. Obviously, and for the present and future good of the three who are involved, the hospital staff physician, the practitioner and the patient, a cooperative relationship should be established and maintained. This requires understanding, mutual aid, good will and a true scientific spirit.

The problem for the hospital executive is purely administrative. No question of an open or closed hospital is involved, unless the hospital wants it so. The estrangement between the practitioner and the hospital which has passed him by, in emphasizing its favors to his scientific superiors, is provocative of all kinds of evil. It is not enough for medical schools to offer graduate courses to practitioners, for medical societies to invite them to meetings and for publishers to offer them professional journals to read. The best educational material is at hand in their own practices and it is from this material that they can learn most, with a little help, while not neglecting to accept other educational facilities. Rare cases are rare cases. It is the practitioner who sees routine medicine at its best and most hopeful stages.

Opportunities for the stimulation of the scientific spirit are much more numerous in hospital than in private practice. Cases in logical series are more readily observed and studied in a hospital that has the necessary facilities and personnel. Since no economic problem for the patient is involved in bedside visits, they are continuous. Special diagnostic and therapeutic facilities are readily available, and frequent consultations are not the least of these. The wards are, in fact, clinical laboratories. The patient who is in the hospital is removed from the diverting influence of relatives and friends whose changeable tactics are the bane of the practitioner's life.

The practitioner constitutes the backbone of medical practice, at least as far as the poorer classes of the community are concerned. He refers his patient to a hospital if the condition requires surgical intervention, or is progressive and not subject to control with the limited facilities of the home. Poverty alone may be the cause. Often the physician in referring a patient to a hospital for continued care does so in the knowledge that alone he is unable to solve the clinical problem.

Ways to Meet the Problem

Specific recommendations to further cooperation between hospitals and practitioners are: (a) The practitioner should be informed of the disposition of his patient. (b) His record of the previous history of the patient should be requested. (c) He should be invited to the wards for the purpose of acquainting him with the findings of the staff (this is good practice for the intern who will be a practitioner himself some day). (d) He should be notified of operation or postmortem examination. (e) He should be notified when the patient has been discharged and advised about further care at home.

The good will of the practitioner is no small asset to any hospital. With closer cooperation the hospital may expect cases that have been better prepared, studied and recorded by the practitioner before the admission of his patient to the hospital. A policy of this sort would put the physician on his mettle, knowing as he would the scientific standards of the hospital that welcomes him. It would point the way to better medicine by giving him an opportunity to see the other type of medical practice in which the clinical picture is clearer and more orderly. The training and experience of hospital staffs should be made freely available to the practitioner if the fundamental obligation of the hospital to teach medicine is to be fulfilled.[1]

[1]Read before the New York State Hospital Association.

Population Changes That Will Affect Hospitals

That population changes now taking place will necessitate changes in the type of hospital service offered is the view of this author who urges that thought be given to the question before the need for change becomes urgent

By WARREN S. THOMPSON

Scripps Foundation for Research in Population Problems, Miami University

IT IS perhaps not sufficiently realized that considerable changes are taking place in the growth and make-up of our population and that these changes will have much effect upon many, if not most, of our institutions. The changes which most concern all of us are probably those consequent upon the decline of the birth rate and the increasing proportion of older people. Since the facts showing these two fundamental changes are not generally known it may be well to present them briefly before undertaking to point out their significance to hospitals.

In 1854 shortly after the collection of vital statistics was begun Massachusetts had a recorded birth rate of 29.0 per 1,000 of the total population. At that early time it is highly probable that birth registration was considerably less complete than it now is; but even so the rate of 1854 was just about twice as high as the rate in 1934 (14.7). The use of data for Massachusetts, however, is misleading for even before 1850 the birth rate in Massachusetts had already declined to a point much below the average for the United States. An estimate for the white population in the United States in 1850 places the crude rate (births per 1,000 of the total population) at 43.3 per 1,000 and the rate per 1,000 women 15-44 at 194. By 1930 these rates had fallen to 20.1 and 87 respectively. Obviously there has been a tremendous decline in the birth rate in recent decades and this decline has as yet shown no slackening which can be regarded as permanent.

Fewer Babies Since 1921

It needs no argument to prove that when fewer babies per 1,000 of the population are being born, and fewer in absolute numbers since 1921, every year witnesses an increase in the proportion of the total population passing into the older age groups. Besides, in this country the presence of a large number of immigrants, most of whom entered around twenty years of age, tends to increase the proportion of older people as soon as births fall off. The accompanying table will show how the proportions of the population in the more important age groups have changed since 1880 and the probable changes during the ensuing forty-five years.

This table shows that whereas 39 per cent of our population is now under twenty and only 23 per cent forty-five or over, in 1980 there are likely to be only 25 per cent under twenty and 40 per cent forty-five or over. The proportion over sixty-five will increase about two and one-half times by 1980 while our total population will probably be very little larger than it now is.

These great shifts in the age make-up of the people cannot fail to exercise a profound influence on our lives in many respects. It is not our purpose here to do more than point out how some of the more important changes may affect the problems of hospitals. Even to do this is beyond the power of the layman in many respects because he cannot know just how these population changes will affect the medical problems involved in maintaining the health of an older population.

An examination of the causes of death during the last thirty to forty years shows that some diseases have been greatly curbed during this period but that little headway has been made with others. Thus the acute diseases such as typhoid fever, diphtheria, scarlet fever, measles, and diarrhea and enteritis have pretty well come under control in recent years. In the United States they now take only from one-tenth to one-half the toll they did at the beginning of the century. One

might even add to this list tuberculosis and influenza and pneumonia. Truly we have reason to be proud of our achievements in this matter.

On the other hand, cancer, diabetes, cerebral hemorrhage, diseases of the heart and arteries and nephritis have been taking an increasing toll of human life. Furthermore, except for tuberculosis, influenza and pneumonia, the rates for older people have increased at the same time that the rates for younger people have declined. In other words there is nothing in our vital statistics to encourage the belief that thus far much progress has been made in the control of the organic and chronic diseases which cause a large majority of the deaths of elderly people.

The lowering of the death rate of which we are so justly proud has been achieved largely by the conquest of the diseases of early childhood. The significance of the age changes in the population and of changes in the vital rates as they are likely to affect the hospitals can be stated very briefly; indeed, all a layman can do is to indicate the general nature of the new health problems which these population changes will present to the hospitals for solution.

In the first place it appears that hospital facilities to care for confinement cases need not be expanded much, if any, in the near future. Even a considerable increase in the proportion of confinements taking place in hospitals can probably be cared for, since the actual number of births in 1934 was between 600,000 and 700,000 fewer than in 1921. Only if there should be a rapid and great improvement in economic conditions or a great increase in the public funds available to hospitals for the care of mothers in economic groups which heretofore have not been able to afford the luxury of a hospital confinement, would there be need for additional maternity facilities.

No doubt it is only the limited economic resources of most people which prevent a much larger use of hospitals; for certainly at present there is no morbidity group being cared for 100 per cent effectively according to the best hospital standards. But assuming little change in general economic conditions it seems likely that in the near future there will not be much increase in the demand for hospital facilities for confinement cases.

On the other hand the age changes noted above and the stubborn nature of the chronic and organic diseases of the elderly would seem to the layman to indicate a great increase in the demand for hospital services to the aged and to those with chronic ailments, even though there should not be much increase in public health expenditures for these diseases. Even the layman can appreciate the fact that the adequate treatment of diphtheria and cancer makes altogether different demands upon the hospital and it appears that the treatment of the latter will certainly be the more costly because it will require such a large increase in skilled medical and nursing service.

It seems likely, therefore, that the hospital facilities for the treatment of the acute diseases of children and young adults will be less and less needed, or at most will need less expansion than the facilities for the treatment of the organic

PERCENTAGE DISTRIBUTION AND RATE OF INCREASE BY AGE FOR THE TOTAL POPULATION, 1880-1980

Year	*0-4*	*5-19*	*20-29*	*30-44*	*45-64*	*65*	*Total*
				Percentage Distribution			
1880	13.8	34.3	18.3	17.6	12.6	3.4	100.0
1890*	12.2	33.9	18.3	18.6	13.1	3.9	100.0
1900	12.1	32.3	18.3	19.5	13.7	4.1	100.0
1910	11.6	30.4	18.8	20.3	14.6	4.3	100.0
1920	11.0	29.8	17.4	21.0	16.1	4.7	100.0
1930	9.3	29.5	16.9	21.5	17.5	5.4	100.0
1940	8.0	26.4	17.2	21.2	20.6	6.6	100.0
1950	7.2	23.3	16.6	22.6	21.8	8.5	100.0
1960	6.4	21.7	15.0	23.0	23.4	10.5	100.0
1970	6.0	20.1	14.4	21.7	26.1	11.6	100.0
1980	5.8	19.2	13.7	21.2	26.8	13.3	100.0
				Percentage Increase			
1880-90*	10.4	23.0	24.6	31.6	29.9	40.3	24.5
1890-1900*	20.1	15.8	21.4	27.0	27.0	27.4	21.3
1900-10	15.9	14.0	24.3	26.2	29.1	28.2	21.1
1910-20	8.9	12.7	6.5	19.1	26.9	24.9	15.0
1920-30	−1.1	14.9	12.7	18.6	25.7	34.5	16.2
1930-40	−8.1	−3.8	9.5	6.3	26.5	32.1	7.4
1940-50	−6.3	−8.1	0.5	10.5	10.3	32.2	3.9
1950-60	−10.1	−6.7	−9.2	2.6	7.9	24.4	0.5
1960-70	−8.4	−9.3	−5.8	−7.8	9.1	8.6	−2.2
1970-80	−8.2	−8.6	−9.2	−6.3	−1.6	9.6	−4.2

*Excluding 325,464 persons specially enumerated in 1890 in Indian Territory and on Indian reservations for whom statistics of age are not available.

diseases of older people. For a number of decades it appears that there has been very little improvement in the death rates of people aged forty and over while at sixty and over there is some evidence that death rates are higher than in the past.

The student of vital statistics knows better than most people that heretofore the public health movement has largely concentrated upon saving the lives of babies and young people and that comparatively little attention has been given to improving the health of older people. It appears, therefore, that in the future, more and more attention will have to be given to the health of the middle-aged and aged, to ailments which are not acute but rather organic, indicating an incipient or an actual break down in the general functioning of the body.

Since the methods of diagnosis and treatment of organic and chronic ailments are vastly different from those used in dealing with acute diseases, it appears that hospitals which must bear the brunt of this new public health attack will have to undertake many new functions or at least will have to expand largely their facilities for the diagnosis and treatment of organic ailments. So far as the layman can judge the treatment of organic troubles is far more costly and requires a higher grade of medical training and knowledge than was needed to reduce the death rate from acute and infectious diseases. In the future, then, the hospitals seem likely to be faced with the necessity of making some difficult and expensive adjustments and this at a time when they will probably find it even harder to assume new financial burdens than in the past.

The technical problems involved in this shift in the proportions of the different classes of patients hospitals may expect as a consequence of the changing age composition, lie entirely beyond the ken of the layman. All the student of population and vital statistics can say is that the changes in the growth and the composition of our population which are now taking place will render certain traditional types of hospital service less necessary than they have been in the past and will bring into greater and greater demand certain other services which hitherto have been of minor importance. It can also be said, unless hospitals are far more adaptable than most other human institutions, that there will be a considerable lag in time between the rise of need for an expansion of hospital service for organic and chronic diseases and the development of this service in adequate amount and quality. But the sooner it is realized that such a change is inherent in the population changes now taking place, the sooner it will be initiated and the shorter will be the period of inadequacy.

London to Have Women Orderlies

A proposal to employ women orderlies in twelve of the general hospitals for acute diseases which are a part of the hospital system controlled by the London County Council, London, England, was recently made by the Hospitals and Medical Services Committee, according to a London correspondent of the *Journal of the American Medical Association*. These orderlies would be employed in addition to, or in substitution for, a proportion of the probationer or assistant nurses in the twelve hospitals which are recognized as training schools for nurses.

The proposal originated after the council recently took over hospitals which were under the control of the local authorities in two of which women orderlies were employed. Their work in these two institutions made it seem advantageous to the committee to employ them elsewhere. The results of the council's nursing examinations had also emphasized the fact that the probationers needed more practical training.

The proposal, which originated with the socialist element now controlling the London County Council, was opposed by Dr. Barrie Lambert, a woman physician, former chairman of the committee before the present incumbency. Her objections were that many of the duties to be entrusted to orderlies are highly important to the training of a nurse. The use of untrained women for work that should be done by a probationer under the supervision of a nurse would lower nursing standards.

Furthermore the proposal to assign to orderlies such duties as assisting in blanket-bathing, dressing, moving or making beds for which two persons are required, would be robbing probationers of valuable instruction which they should have.

In spite of these objections and the fact that the new orderlies would involve an extra expenditure of $410,000 annually, the proposal was adopted.

White Male Attendant

In hospitals that depend mainly upon colored orderlies, the problem of the male private patient who objects to receiving certain procedures at the hands of a colored man or women nurses, arises. In institutions of sufficient size a white male attendant has proved satisfactory, his duties being to serve the male private patients who do not have special nurses. His work may be limited mainly to catheterization, irrigations, enemas and dressings of the G-U tract. A schedule maintained at some central point helps to ensure the most economical and efficient use of his time. Such a man relieves greatly the work of floor nurses, who find that such procedures interfere seriously with their routine duties on busy floors. The method also provides a greater degree of skill than is possible where a large number of orderlies are called upon to do such work, for which they cannot all be adequately trained.—*F. Stanley Howe, Orange Memorial Hospital, Orange, N. J.*

The Superintendent Inspects the Far Places*

A continuation of the hospital round begun last month wherein the unpleasant and irksome corners in the basement and elsewhere are remembered

IN MAKING rounds the medical superintendent is inclined to direct his attention to practices that concern the intimate medical care of patients. It is unusual to find either a medically trained executive so well balanced that he is equally skilled and interested in the business and scientific work of the hospital or a lay superintendent who does not give preponderant attention to matters of business.

As cold weather approaches certain matters of purely seasonal occurrence demand attention. How, it may be asked, may frigid temperatures harm hospital property? It can be easily understood that during the pre-summer months there are such matters as screening, the repair and placement of fans and attention to the sanitation of garbage plants and kitchens which do not require equal attention at other times. It would be proper for the superintendent as winter approaches to bring to his board of trustees a report of his rounds pointing out the necessity for certain physical repairs in preparation for a cold winter. An institution not properly insulated against the rigors of winter is of course most expensive from the standpoint of heating.

When Winter Comes

It is at this time that the executive should make certain that doors and windows are tight, and, in locations where temperatures are extreme, that storm sash and doors are in place and in good repair. Where long runs of heating pipes are to be found, it is money well spent to insulate them against the radiation of costly heat. Roofs which may have hitherto appeared tight are likely to develop leaks due to the expansion and contraction incident to the vagaries of winter. Sidewalks and roads, if neglected, will heave from the ice and frost and hence will require major repairs when spring arrives. How often in the carelessly conducted hospital one observes eaves troughs and vertical water conduits spouting water because they have frozen after becoming obstructed with débris. A little attention to this matter prior to the arrival of freezing days will save much money.

Windows leading to shallow basements if properly closed will prevent the freezing of pipes and loss of efficiency in the heating system. Fire escapes and other emergency exits and areaway drains may be inspected on this same out-of-door tour. The wide-awake executive does not allow summer days to pass without devoting the necessary attention to overhauling his heating plant. Fouled boilers and tubes lower heating efficiency and add many dollars of expense from the standpoint of fuel consumption. Building masonry will be pointed and outdoor surfaces of sash and doors painted if the superintendent is aware of the necessities and possibilities of the slack days of summer and fall. Now that the executive and his party have inspected the exterior of buildings, they may devote their attention to the hospital morgue.

Do You Give Absent Treatment to the Morgue?

Naturally the morgue is neither cheerful nor inviting and is therefore likely to receive much absent treatment at the hands of the superintendent. The morgue is frequently in the laboratory building or in some institutions it may be found in a separate structure, usually at the rear of the hospital plant. This spares patients the gruesome spectacle of the embalmer's conveyances coming and going. It is supposed by some that spaces devoted to the housing of the bodies of deceased patients and to the performance of autopsies do not require the same degree of cleanliness and sanitation as other portions of the institution. This is entirely erroneous. The dead deserve the same respect and careful, even gentle, handling as do patients in the hospital.

Something of the morale and efficiency of the hospital personnel can be learned by observing the technique employed in the preparation of bodies for removal from the institution and the manner in which autopsies are performed. If an examination of a body is in progress as the inspecting party reaches the morgue, the presence or absence of smoking on the part of those engaged, the strictness with which rules governing

*Practical Administrative Problems Series.

routine incisions are observed and the methods employed in the closure of such incisions are matters which deserve the attention of the hospital executive.

The inspection of storage boxes as to sanitation and cooling should be of vital interest to the executive's group. In many hospitals the transportation of the dead and the receipt on the part of a morgue attendant for a body are carelessly performed. Again one observes insanitary storage boxes employed for the temporary preservation of amputated limbs and other pathologic specimens. It is of interest at this juncture to remark that here and there rules exist which require the preservation of such specimens for a stated period of time. Again it is sometimes necessary to accommodate religious beliefs as to the proper disposal of amputated limbs, for example, by burial. Some hospitals require that a definite release be signed by the members of the patient's family before such specimens are destroyed and others require in the absence of such a release that they be kept for at least thirty days.

Facilities Needed to View Autopsies

Too often in the postmortem room there is a total absence of facilities for the comfortable observation of the autopsy by visitors. Again the morgue is cold and improperly lighted and withal a place which is far from inviting and which therefore mitigates against a high postmortem percentage and discourages the presence of surgeons and clinicians interested in the comparison of ante and postmortem findings. It is a hideous practice to place the morgue in a sub-basement of the hospital, a location which presents difficulty in ventilation and prevents the unobserved transportation of bodies.

It may be here remarked that the methods practiced in some institutions in the disposal of the bodies of stillborn children are open to severe criticism. Recently in an Eastern city the police were much agitated by the discovery of a premature infant in a street waste receptacle. It was later learned that a careless medical student into whose hands had come this pathologic specimen, had without any criminal intent employed this questionable method of disposing of it. It behooves the executive, therefore, to work out methods by which bodies of infants stillborn in the hospital and later unclaimed by relatives and released by civil authorities shall be properly and completely disposed of by burial or incineration.

It may appear to some as a trivial matter to inquire whether gowns or shrouds belonging to the hospital are being lost each time a body is removed from the institution. Undertakers, or even relatives of the deceased patient, should be required to reimburse the hospital for these articles or else return them when they are no longer necessary.

The destructive attitude of undertakers which results in the loss of autopsy permissions is an interesting problem which can be solved only by education or by pressure brought by the hospital executive upon these persons. As an additional matter of inquiry, the possible presence in and about the hospital, of undertaker's agents or others paid by the embalmer, is an important subject for study. It is a well known fact that here and there an illicit connection has been established between an undertaker and someone in the employ of the hospital who has knowledge of the death of a patient and hence for the need of the services of an embalmer.

The next place to be visited is the garbage plant. Often not much attention is paid to the sanitation of this portion of the property. When garbage is weighed sometimes it is the duty of the hospital employee assigned to this plant to compile these records.

Too often gross carelessness is noticeable in the strewing on the soil surrounding the garbage station of liquid or solid refuse which, sinking into the ground and freezing there, creates when spring comes a splendid breeding place for flies and other vermin. Winter and summer cleanliness should exhibit one and the same standard. Here are usually to be found steam and water facilities for the cleansing of garbage cans. This again is frequently a procedure characterized by carelessness and inefficiency. Someone has remarked that garbage cans should present a state of cleanliness second only to that of the dishes in the kitchen if they are to be prevented from serving as insect breeding places. Garbage pits must, of course, be covered and possess cement bottoms. When properly constructed and supervised, even though located adjacent to buildings occupied by patients they should offer but few objectionable features from the standpoint of cleanliness and odors.

Ambulances Should Be Immaculate

If the hospital conducts its own ambulance service the garage deserves close supervision by the executive. No matter how many cars the hospital may maintain, the place of their storage and repair should be immaculate. The ambulance is the temporary quarters of many of the hospital's patients and it should be as sanitary and clean as the wards and private rooms. The inspecting party should carefully observe the cleanliness of ambulance linen, the completeness of ambulance

emergency kits and the methods employed in the protection from theft of the medicines, instruments and supplies therein. The public would not be highly impressed could it observe the lack of orderliness and the incompleteness of equipment of the average ambulance physician's bag.

What methods are employed in preventing the theft of such automobile necessities as tires, gasoline, oil and tools? If the hospital maintains a tank from which it dispenses necessary fuel for its automotive equipment, the methods employed in the receipt and issuance of gasoline should be of much interest. Unfortunately the theft of hospital gasoline or carelessness in its receipt and issuance are not unknown occurrences in even the best conducted hospital. Moreover, the use of such hospital movable equipment as trucks and ambulances for personal purposes is not an unheard of occurrence.

A Matter of Mileage

What methods are employed in checking the mileage secured from tires purchased by the hospital? Sometimes chauffeurs condemn tires and secure new ones because of the possibility of deriving some personal commission from the dealer, especially in large public hospitals where the magnitude of the executive's task prevents careful attention to garage practices. It is not advisable to permit the cars of employees to be stored in and about the institutional garage. When this is done temptation is present to devote institutional time to the repair of personal cars or to direct into wrong channels hospital gasoline, tires or tools. It is often complicating for the executive to sell gasoline to employees for their own use even though some advantage in price to the latter can be secured thereby.

The hospital storeroom is now visited by the inspecting party. Does an atmosphere of orderliness and tidiness exist here or is the floor littered with broken cartons or bags and containers partly emptied of their contents? The storekeeper should have at his fingertips information relative to understock and overstock and to the methods by which he safeguards the institution in the receipt and issuance of goods.

Are shelves devoted to an orderly arrangement of each type of article properly labeled or is it to be seen that the question of the absence or presence of goods is a matter of personal knowledge and memory on the part of the storekeeper? In such cases, the temporary absence of the one in charge is likely to lead to great confusion and requisitions for the purchase of new goods are likely to be forwarded through ignorance that the articles of the type requested are in stock.

What persons are permitted to enter the storeroom? Who possesses keys for use at times when this department is closed? What is being done with worn-out equipment and what effort at salvage is being put forward? The frugal storekeeper is one to be greatly treasured and yet there is a type of employee who is inclined to question the need for the articles requisitioned or to make it difficult for nurses and physicians to secure the necessities of their work because of a falsely directed economy. It should not be the practice nor should it be the prerogative of such an employee to decide as to the bona fide nature of the requisition.

It should be interesting for the inspecting party to visit out-of-the-way storage places in the institution. Attics and cellars are frequently littered with broken furniture, discarded wheel chairs, mattresses and out-of-date enamel and dishware. Executives too often are of the string-saving type who can never bring themselves to throw anything away. Hence an accumulation of worthless material is likely to furnish a fire risk. Basements poorly ventilated and piled to the ceiling with such articles covered with dust of an inflammable nature, are likely to present a real danger to the lives of patients.

It is a good practice from time to time to carry on here a real New England house cleaning and to catalogue those articles which deserve saving and with a rather ruthless hand, to discard those likely to be useless. Moreover, such spaces too frequently harbor vagrants and vermin. During the cold season unused basements of commercial as well as hospital buildings have been known to have served as sleeping places for vagrants for many weeks, creating thereby a fire risk. Hence it may be concluded that the superintendent should not avoid soiling his hands or even his linen in inspecting below ground areas in his hospital plant even though the more commonly frequented places may be orderly.

What About the Laundry?

The superintendent and his group now reach the laundry. It is not possible here to describe a proper washing technique but one may observe the presence of an orderly or a hit-and-miss scheme in the progress of linens from the soiled to the finished product. The average superintendent knows little about the intimate practices of the laundry. Too often it is a cold, drafty and damp place to be visited only when necessity urgently requires. He rarely knows the condition of the retiring room for female workers or the other difficult conditions under which his personnel daily labor. The careless use of supplies, the pres-

ence of leaking and hence expensive washers, the method of the storage of soiled linen before it reaches the washer, the means employed in removing stains, the presence or absence of expensive steam leaks all are matters frequently beyond his ken.

In the average laundry even the casual observer can detect an atmosphere of industry as if its workers were going somewhere or of spiritless lethargy which augurs not well for the volume of work produced. What is the relationship between the laundry and the central linen room? When, each day, is the first clean linen delivered to the latter? What steps are taken to prevent the loss of this valuable hospital property? Is there sufficient linen daily in storage so that prompt delivery can be made each morning or must some linen be washed before it can be returned? What steps are taken to withdraw from circulation torn or stained linen and how is this accurately replaced? All of these matters can be rather quickly learned when the executive visits his laundry and can rarely be ascertained from his desk.

A full knowledge of the functioning of the ice plant, the methods of preventing contamination of either the water or the finished ice, and a careful inspection of the power plant are interesting problems that face the superintendent and his group.

This article should not be concluded without mention of the necessity of good housekeeping in the nurses' and helps' quarters. High morale cannot be expected of these persons unless proper living conditions are given them. Perhaps no other groups in the hospital personnel are more routinely neglected in this respect than the orderlies, waiters and porters. Much to the detriment of the hospital's reputation for fair play it must be said that all over the country workers in these groups are the victim of careless and unjustified hospital profiteering insofar as their living accommodations are concerned. Nurses and interns have those who may take their part. They act as defenders of their rights but this is not true of the orderly group. The superintendent now returns to his office and dictates the results of his inspection, the practical benefits of which will only be reached when at his next staff conference directions are given for the correction of the defects observed.

Pictures to Hang in the Patients' Room Should Be Colorful

Any person who visits many hospitals must be impressed with the variety of subjects chosen to decorate the rooms of patients. Of course, many hospital decorators hang no pictures in the hospital bedroom, preferring to depend for decoration and interest entirely upon the color scheme and curtain hangings. While this viewpoint may be conducive to cleanliness in the room, there is an increasing desire to make the hospital bedroom look as homelike as possible, with the natural result that pictures are more often found upon hospital walls.

What pictures make the happiest choice? On the whole, those which seem to meet with most general approval are ones which are bright, colorful and blend harmoniously with the color scheme of the room. Color prints are more desirable than black and white or sepia reproductions, but many of the more fashionable colors are distinctly irritating and more harmonious combinations should be chosen.

Action pictures, such as the popular Chariot Race, are not liked by the patient who desires to rest. Many fine old wood cuts and etchings with a great deal of intricate detail are found in hospitals, but these often worry patients who cannot get close enough to interpret the detail and the picture becomes a focus of irritation.

The ever popular studies of Greek or Roman ruins, so frequently seen in doctors' waiting rooms, do not make a good choice for the hospital bedroom, because of the natural tendency to make the patient philosophize upon the passage of time and the decay of even pillars of marble. Above all, where rooms are furnished in memory of departed relatives of the donor, the portrait of the deceased individual in whose memory the room has been furnished should not be hung in the room where the patient can spend long, weary hours thinking of how in a short while he also may be as is the gentleman in the frame.

If pictures are to be hung in hospital rooms—and there is much to be said in favor of well chosen pictorial decoration—the happiest choice is perhaps a simple color print of flowers. The subject should be carefully chosen, particularly as to color combinations, should not be too large or too minute and should be framed simply and unostentatiously, possibly with a nicely proportioned mat. Such a choice is generally acceptable to practically all types of patients.—*G. Harvey Agnew, M.D., Department of Hospital Service, Canadian Medical Association.*

Utilizing Unproductive Space

Many hospitals have rooms that are yielding no return. All of the space of a hospital should bring a return, either in money or in good will. It is suggested that a survey of the hospital be made in order to determine whether or not all space is being used to the best advantage. An impartial survey may result in more comfortable waiting rooms, or in a readjustment of departments because of the inadequate quarters of one or two. On the other hand, if one has imagination, room may be discovered that might be used for an entirely new project, a project with possibilities so great that less money may be required for red ink.—*Ada Belle McCleery, Evanston Hospital, Evanston, Ill.*

PLANT OPERATION • • • •

Conducted by John R. Mannix and R. C. Buerki, M.D.

Ways to Exterminate Bedbugs

By Joseph Laferriere
Consulting Entomologist, Boston

AS LONG as bedbugs confine themselves to beds, they present an easy problem that can be handled by any housewife. That is why they are rare in isolated houses of the better class. These insects are introduced into hospitals through visitors who carry them from their homes, or from hotels or apartment houses, or more often from warm, dark theaters, which are excellent breeding places and often need fumigating. Invasion from the congested city districts must be common enough.

Most of the bedbug liquids sold in retail stores are composed of kerosene, or of oils that are within the kerosene fractions, as is evidenced by the labels that carry the warning, "Inflammable" or "Combustible Material." These are deadly one-minute killers. There is no need to worry about their toxicity when they come into actual contact with the insect.

Bedbug liquids do not require expensive paralytics, like pyrethrum or derris extracts, which are now added to fly sprays to reach fast flying insects. These commercial bedbug liquids are highly refined to remove some of their odor, and lightly perfumed to mask the rest. Also, they are usually nonstaining, and can be sprayed on bedclothes or wall paper. They are perfectly satisfactory for mild infestations and inexpensive when bought by the drum.

But most liquids include carbon tetrachloride to make them noninflammable, which is important in any exterminating job. Carbon tetrachloride is used in many fire extinguishers. Furthermore the carbon is nonstaining and evaporates without leaving a trace. When it disappears, it does not leave a lingering kerosene odor. As a dry cleaning fluid, whole garments can be dipped into it, with no injury to their sizing or pleating. As a solvent for fat, it is a good paint cleaner. But the mixture must contain at least 20 per cent of kerosene or it will evaporate before it can penetrate the eggs to the embryos. Petroleum companies carry a kerosene that is specially refined for insecticides. Or the carbon tetrachloride can be mixed with commercial bedbug liquid. The formula is 80 per cent carbon tetrachloride; 20 per cent kerosene; oil of wintergreen, about 1 ounce to a gallon. A few drops on a piece of white paper is a good test for staining, evaporation and odor. It is better also to try it on the woodwork, because new chemicals sometimes appear in paint and varnishes. You should be able to spray the liquid abundantly on anything.

Insect powders are impractical in bedbug control. Corrosive sublimate and oil of turpentine would be of some service. But repellents would simply harry the insects out of the bed to take refuge in the walls and floors. The liquids, which can be so easily applied, are far more effective.

The first signs of bedbug infestation are blood stains on the sheets.

Last month we exterminated the roach and the war goes on. This time we have declared against the insect dreaded greatly by all housekeepers—the bedbug

Nurses should be trained to notice them and report at once. Many patients do not even feel the bites and would not complain. The insects may have lodged on the mattress at the head of the bed or in the crevices of the bed. The first treatment is very simple; the liquid may be applied with a syringe and sprayed along the seams and tufting of the mattress and into the cracks and crevices of the bed. If the insects continue to appear, the bed needs a more thorough cleaning, with a more liberal application of the liquid, not neglecting the springs.

The insects will seldom enter the mattress save in cases of extreme infestation. That would never happen if the mattress were made insectproof with a strong cover sewed with a double or triple stitch. This second application will destroy every insect in the bed, and thereafter a monthly inspection will suffice to keep it clean. Bad infestations are always the result of negligence or of ineffective remedies, for the bedbug, like the roach, is a slow breeder.

If bedbugs still appear after thorough cleaning of the bed, it is proof that the insect has begun to nest in the furniture or the walls or the floor. Fortunately, in modern hospitals the walls are solid and the furnishing of rooms and wards so simple that the insect cannot find many places of concealment. But, on the other hand, its protective instincts are highly developed through years of cohabitation with its messmate. If things are not quite to its taste, it is apt to migrate from room to room, or from floor to floor. Before morning it may leave the bed and go to distant quarters for protection and hiding. In one case, it was known to nest in the library far from the sleeping quarters and visit its host by night. Fortunately it is just as gregarious as the roach and congregates in tight clusters. In bad infestations it is everywhere and will even drop down on the fumigators from the ceilings.

If the insects have started to breed outside the bed, a real exterminating job becomes necessary. This is what we call the service call of the exterminator. In a private room it is better to empty the closet and drawers of the bureau; then the bedding is removed and the mattress folded over. For spraying, a small air pressure gun is required, that can throw a jet up to the ceiling. It costs but three or four dollars in seed stores or chemical supply houses. To destroy all the eggs, it is sometimes better to take the bed apart and spray the joints, slats, springs, and mattress, especially the seams, bindings and tufts.

After spraying the cracks in the furniture, in the closet, in the floor, the jet is directed along the top and bottom of mopboards, then up the walls in the corners to the ceiling, then along the top of the walls and the moldings. A quart for each room is the usual dosage. When possible, wards are treated in the same way. If the insects have not disappeared after two or three of these treatments, it is better to resort to some of the new fumigants which can be applied in a room or ward without the rest of the building having to be vacated.

Even sulphur fumes are still practicable for a room or a small ward. Candles, with directions, are for sale everywhere in drug stores. Or the sulphur may be burned in an old pan, which for protection must be placed in a larger receptacle containing at least one inch of water to prevent overflowing. A little quantity of wood

Make this test for TENSIL STRENGTH

. . . it will influence you to specify HORCO

the all-purpose lightweight, waterproof, rubberized fabric that is expressly designed to withstand the hard usage of hospital routine wherever waterproof material is indicated.

Horco can be washed, boiled and repeatedly autoclaved without peeling, deterioration or other harmful effects. Its serviceability is not in the least affected by contact with urine, alcohol, blood, diluted acid or alkaline solutions, ether, sun's rays or organic exudates over prolonged periods.

Horco is odorless, soft and smooth. Its delicate flexible "give" to body movement greatly reduces the possibility of pressure sores incident to heavy, coarse or less flexible materials. Its characteristics of comfort appeal to the most sensitive and fastidious patient.

Horco is economical, too. Available in 25 and 50 yard bolts, 36″ in width, ivory or maroon colors, it presents the ideal waterproof fabric for sheeting, pillowcases and other sanitary unit requirements.

Ask Your Dealer for prices on yardage, ready-made hospital units and garments.

MANN SALES COMPANY
National Distributors
369 LEXINGTON AVE. NEW YORK, N. Y.

HOSPITAL HORCO SILK
Product of Hodgman Rubber Co.

We should be pleased to send you more complete information relative to the superior advantages, resistance qualities and sewing technic of HORCO. The attached coupon may be conveniently used for this purpose.

Mann Sales Company,
369 Lexington Ave., New York, N. Y.

We should be pleased to receive further information on Horco Hospital fabric.

.....

Street.....

City.....*State*.....

alcohol poured over the sulphur will make it burn. There is less danger of bleaching in the fabrics and furnishings in the winter when the air is much drier. Corroding of metals may be prevented by covering them with a coat of vaseline. But because of the fire hazard this fumigant is prohibited in some insurance policies. The dosage is 2 pounds for each 2,000 square feet of room space, and the room must be closed for at least five or six hours, or preferably for twenty-four hours. The fumes will kill the eggs as well as the insects.

Carbon disulphide, another old favorite, is more toxic, is inexpensive and available in drug stores and chemical supply houses. The liquid is not explosive, but the gas is highly inflammable and explosive, like the vapor of gasoline. The same precautions must be taken as in the use of gasoline, and there must be no smoking or carrying around of lights; even the heating system should be turned off. In practical work, fumigation with this chemical should not be done at temperatures below 60° F. If the room is not gastight, as much as 20 pounds per 1,000 cubic feet of space is required to kill the insects. Exposure should last twelve hours.

Fire Hazard Is Reduced

Fire hazard disappears completely with the new fumigants. Twenty-five per cent of carbon tetrachloride added to ethylene dichloride makes a splendid noncombustible mixture and is relatively harmless to man. It is readily purchased in tins and can be applied by anyone. It gives better results at a temperature of 70° F. For commercial fumigation, Russ recommends a dosage of 14 pounds per 1,000 cubic feet of space.

The ethylene oxide-carbon dioxide mixture is more adapted to general fumigation, but, since it comes only in cylinders, it is better suited to the professional fumigator than to the layman. The ratio of the mixture is 1 part of ethylene oxide to 7.5 parts or more of carbon dioxide by weight. In tight spaces, 10 pounds of the mixture per 1,000 cubic feet of space will kill all insects in from ten to sixteen hours. In spaces that are not tight, it is necessary to increase the dosage and the exposure.

Both mixtures are perfectly safe, since it would require considerable exposure for toxic effect on the operator. Rooms and apartments are now being fumigated without the rest of the building being vacated. This mixture and others of a similar nature are for sale under trade names.

Superheating is now rapidly replacing fumigation for treating whole buildings, especially those that are vacant for a few days during the year. It is just as feasible in a hospital, because the building would also have to be vacated for fumigation. But the cyanide treatment would give a higher kill. So many fatalities are happening with hydrocyanic acid gas that this fumigating method should be left to professional fumigators. However, says Back, "it is quite possible for a careful, well informed person to use hydrocyanic acid gas with safety and with excellent results, particularly in fumigating only one or a few rooms." Complete directions for the use of this gas are given in the splendid Farmers' Bulletin No. 1670, by Back and Cotton (1932).

However, superheating, when possible, is the ideal method, because it is so inexpensive and can be applied by the engineer and the janitor. All flour mills are treated in this way. Bedbugs are very sensitive to high temperatures, and a great number will die at 96° to 100° F. Ross, by means of fires in the heating furnace and in other stoves, obtained temperatures as high as 127° to 160° F. in a two-story house. The test started at 9:30 in the morning; at 4:30 p.m. all the insects were dead. More extensive tests were made by Harned and Allen in the dormitories of the Agricultural and Mechanical College of Mississippi, where 350 rooms were treated. It was only necessary to close the doors, transoms and windows, and turn on the steam heat in all the radiators. There was no need of sealing the cracks. One thermometer was placed in each story. Human beings can endure a temperature of 130° F. without extreme discomfort. According to Stiner, the watchman can make his rounds even when the temperature is at 140° F. Because of the loss of radiation, superheating is more effective in the summer time. Steam heat will give a much higher temperature than hot water.

Harned concludes that killing by superheating begins at 100° F., and is accelerated as the heat increases. There is a total kill after a few hours' exposure at 120°, and a high mortality after two days at 110°. The eggs are killed also. A temperature of 113°, says Marlatt, will also quickly kill the adults of roaches and fleas.

[In the article by Joseph N. Laferriere in the January issue the first sentence in the sixth paragraph (page 69) should read: "Sodium fluoride may be used pure, but it is just as effective when diluted with flour down to 20 per cent."—Ed.]

Analyzing Printed Forms

Michael Reese Hospital, Chicago, made an analytical study of its printed forms with the result that four forms were discarded as unnecessary. Six forms are now made on the hospital's own duplicating machine, and five forms have been simplified, through the removal of unnecessary matter, the elimination of perforation and consecutive numbering, and other changes.

THE HOUSEKEEPER'S CORNER

• Many leading cities of the country have banners of welcome out in honor of the arrival of Mrs. Grace Brigham, president of the National Executive Housekeepers Association. When last heard from, Mrs. Brigham was guest of honor in San Antonio, Tex. Next on her port of call was New Orleans and then a turn-about-face to New York with stop-offs at Philadelphia, Washington and Baltimore. It would not be surprising to hear of many new chapters of the N. E. H. A. as a result of Mrs. Brigham's tour, to say nothing of greater activities among the chapters that are already organized.

• The first in a series of lectures comprising six talks on furniture, housekeeping polishes and detergents and personnel work sponsored by the Philadelphia Chapter of the National Executive Housekeepers Association took place January 9 at Hahnemann Hospital in that city. The course will continue through January, February and March.

• Complete charge of the housekeeping group at the Tri-State Hospital Assembly, to be held at the Hotel Sherman, Chicago, May 6 to 8, rests with Mrs. Alta LaBelle, housekeeper at Michael Reese Hospital in that city. A two-hour group conference with formal papers on housekeeping will take place on May 6, and the following day there will be a conference between the housekeeping group and the engineering group. At the luncheon to be held on May 8, Mrs. LaBelle will give a ten-minute summary of the discussions.

• One of the headliners at the Maryland State dietetic meeting scheduled for February will be Ruth Parker, housekeeper at Sheppard and Enoch Pratt Hospital, Towson, Md.

• Housekeepers in Philadelphia have their calendars marked with a red circle around the date of April 18. It is the occasion of the annual dinner of the Philadelphia chapter of the National Executive Housekeepers Association. Arrangements are being made to make the meeting of this chapter a gala occasion.

• Unusual importance was attached to the meeting of the Connecticut Chapter of the National Executive Housekeepers Association held in New Haven immediately following the national Hotel Exposition in New York City. Several of the hospital women attending that meeting journeyed up to New Haven for the event. Among the speakers was Mrs. Doris L. Dungan, executive housekeeper, Jeanes Hospital, Fox Chase, Philadelphia, Pennsylvania.

They Aid and Abet Skilled Fingers..

BECAUSE Seamless Standard Surgeons' Gloves are anatomically fashioned, they help the surgeon do his job unhampered by any glove restrictions. A finger is a finger, not a tube. Palm, back, thumb and every part are made to fit the hand.

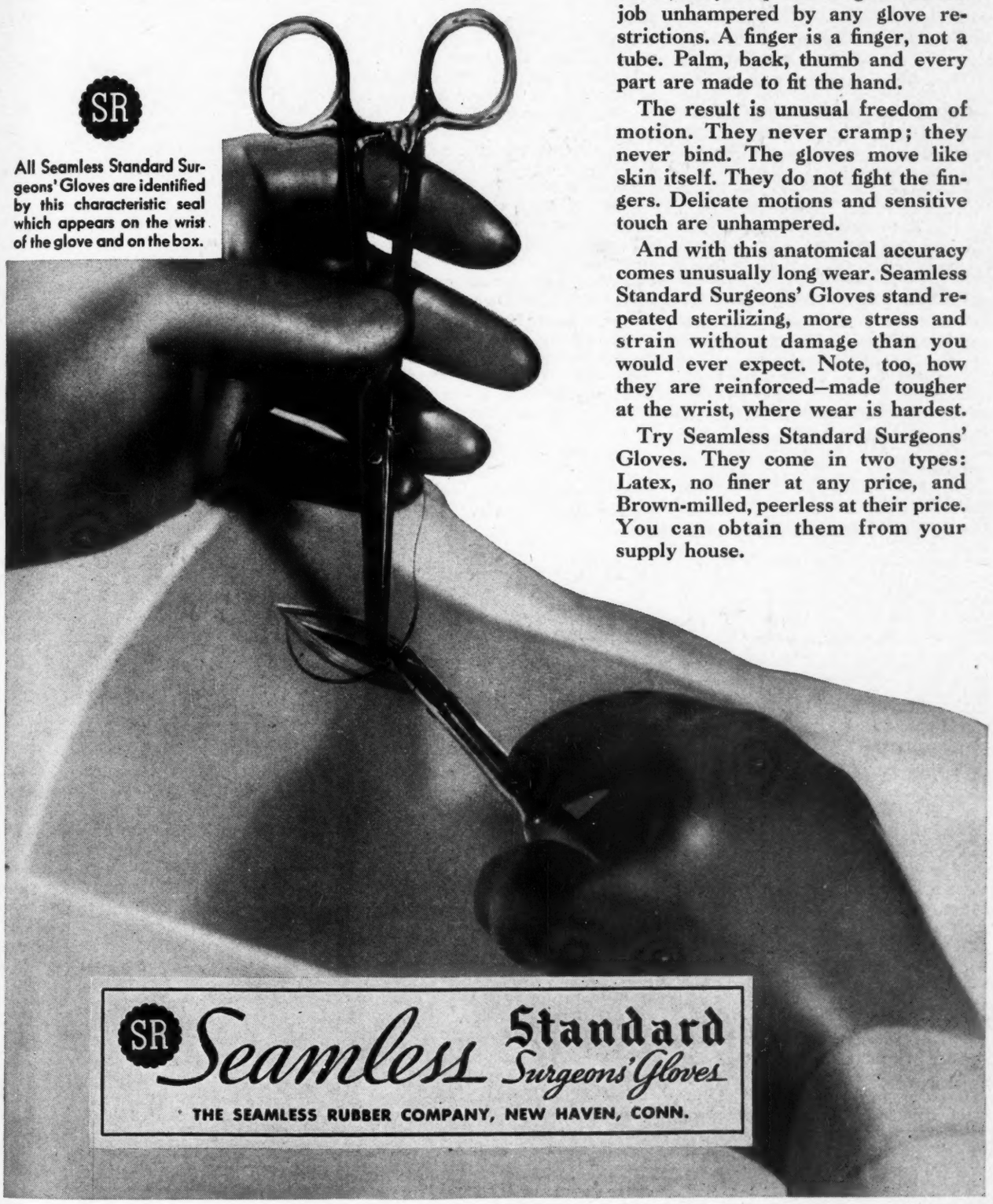
The result is unusual freedom of motion. They never cramp; they never bind. The gloves move like skin itself. They do not fight the fingers. Delicate motions and sensitive touch are unhampered.

And with this anatomical accuracy comes unusually long wear. Seamless Standard Surgeons' Gloves stand repeated sterilizing, more stress and strain without damage than you would ever expect. Note, too, how they are reinforced—made tougher at the wrist, where wear is hardest.

Try Seamless Standard Surgeons' Gloves. They come in two types: Latex, no finer at any price, and Brown-milled, peerless at their price. You can obtain them from your supply house.

SR

All Seamless Standard Surgeons' Gloves are identified by this characteristic seal which appears on the wrist of the glove and on the box.



SR Seamless Standard Surgeons' Gloves

THE SEAMLESS RUBBER COMPANY, NEW HAVEN, CONN.

More than 100,000 Physicians and Surgeons see this advertising every month in the Journal of the American Medical Association, Surgery, Gynecology & Obstetrics, American Journal of Surgery and Annals of Surgery.

Improved Designs for Equipment

By G. W. Olson

Assistant Superintendent, Los Angeles County General Hospital, Los Angeles

WHEN the new acute unit of the Los Angeles County General Hospital, Los Angeles, was completed, the problem of equipping and furnishing it was given careful consideration. At the outset it was contemplated that about three-fourths of the building would be used, giving a capacity of about 1,800 beds. As much as possible of the old equipment was utilized, but this was, to a great extent, a conglomeration which could not be placed in a new, modern building without a good deal of culling and renovation.

It was therefore decided to buy the following items and quantities: 1,200 beds (crank operated Fowler or Gatch type), 100 fracture beds, 100 safety cribs, 1,800 bedside stands, 1,200 mattresses, 1,700 bedpans, 1,000 urinals, 300 irrigator cans, about 2,000 emesis basins, 1,600 washbasins, 3,600 chairs (of which 2,000 were for wards, the remainder for dining rooms and general use), 150 wheel stretchers, 125 wheel chairs, 300 irrigator stands, 150 linen hampers and a large number of pitchers and basins of various sizes. This was ward equipment only, there were scores of other items.

Samples were requested from practically every manufacturer producing these articles. These were carefully examined, tested and compared. The service of competent engineers was secured to pass on them and to report their criticisms and suggestions. It was surprising how many points of comparative merit and demerit these keen technical observers, impartial to a degree which amazed an old hospital man, could find in the samples.

High Cost Fears Allayed

The final result of these examinations was a long list of recommendations for improvements in practically every item submitted. With a definite budget allowance, calculated on the basis of manufacturers' prices tentatively quoted on the samples submitted, I shuddered at the thought of suggesting to manufacturers that even a small portion of the recommended improvements be incorporated in our contracts with eventual successful bidders. Though I am not of a mechanical turn of mind, it did not take much effort on the part of the engineers to convince me of the desirability, practicability and soundness of their recommendations, but because I feared the high cost of what would in effect be custom-made equipment, I hesitated to give my approval until I had consulted some of the principal manufacturers.

To my surprise I found them not only interested, but almost enthusiastically embracing suggestions for improvements in their products. The quantities involved were so large that no firm had enough finished goods or even unfinished or unfabricated materials on hand to fill such an order, therefore they were very willing to consider our prospective contract as outside of their regular production schedule and to leave their customary catalogue prices and discounts entirely out of consideration. Some were eager to receive suggestions of a practical nature for improvement in design and construction of their product, especially when they learned that no restriction would be placed upon their right to incorporate these in their regular line, if they succeeded in obtaining our contract.

Specifications Are Drawn Up

With our fears of exceeding the budget thus happily dispelled, we proceeded to prepare drawings and specifications. Because anything of a mechanical nature to be specially constructed for any department of the county government must pass under the scrutiny of the county mechanical department, whose chief engineer is charged by the board of supervisors with the duty of examining all plans and specifications and affixing his approval, we enlisted the cooperation of William Davidson, chief county mechanical engineer, and received most gratifying assistance from his department. The county mechanical engineer is also charged with the duty of inspecting all equipment contracted for through his office for any department of the county, and only upon his recommendation can it be accepted and paid for. In the performance of this critical function Mr. Davidson and his office cooperated with the hospital authorities in a highly satisfactory manner.

One of the initial steps towards the planning of every piece of equipment was to consult with the medical director and the superintendent of nurses regarding all details which to the planning engineers seemed to need improvement. To most of these consultations these department heads would bring some of their assistants, whose advice was also sought and often proved of the utmost value.

It was decided to adopt metal bedsteads rather than wood, although the latter had been strongly urged by local furniture manufacturers; to avoid white as much as possible, and in order to emphasize the whiteness of linen on the beds, to use color on the metal furniture. A shade of green aptly described as "lettuce leaf green," was adopted. This color had previously been experimented with and found highly satisfactory at the Rancho Los Amigos (the county farm), where it is standard for metal ward furnishings. It was decided that all parts which are exposed to exceptional wear or scuffing should be of rustless metal or should be chromium or cadmium plated, or aluminum lacquered with a special water-white lacquer protective coat. Any wood parts should be of birch or walnut in a light walnut finish, the key for which had been given by the architects of the building in the built-in benches in the clinic waiting rooms, the only woodwork in the entire structure.

With this fundamental outline agreed upon, the details of design and mechanical operation were worked out in drawings by one engineer, while another engineer selected materials and finishes, and accessories such as casters, glides and protective bumpers, and compiled the specifications, naming or describing in minute detail everything that went into the making of the completed article. Particular attention was given by this specification builder to the seemingly minor details of bolts, screws, lock washers and nuts, smoothing of all surfaces and filing of corners, things which nurses have always noticed and suffered from, but which apparently had never been brought definitely to the manufacturers' attention.

Tests Guide Choice

Exhaustive tests were made of materials and finishes by processes simulating actual use and wear. Casters were tested by a contrivance employing a small electric motor to keep them revolving against a wood block with pressure applied equivalent to the weight of a bed with a heavy patient. With this contrivance various well known makes of casters were given the equivalent of a lifetime of wear and then taken apart and examined. The make which survived with the least show of wear was selected. Though higher in price, it was adjudged the cheapest to buy because it promised to give many more years of service.

Various kinds of enamels were tested and the highest priced synthetic product was selected because of its demonstrated wearing qualities. These new paint materials have an affinity for metal surfaces which makes them superior to the old lead, oil and resin products for the finishing of hospital equipment, a point

New improved SURGEON'S BLADE

WINS APPROVAL OF SURGICAL AUTHORITIES!

THE exceptional keenness, uniformity and precision of the new A.S.R. Surgeon's Blades are a complete departure from ordinary standards. Noted surgeons are commenting upon the ease with which these blades perform. They are especially enthusiastic about the uniformity of A.S.R. Surgeon's Blades which is insured by special processing, careful inspection and pre-testing.

In order to present surgeons with a finer, quality instrument, months of research have been spent in developing A.S.R. Surgeon's Blades. During this time leading surgical authorities were daily consulted, so that the benefits of modern technical knowledge and the newest scientific equipment are combined in these blades.

Protected by moisture-proof waxed paper. Available in 9 types—6 blades to a package.

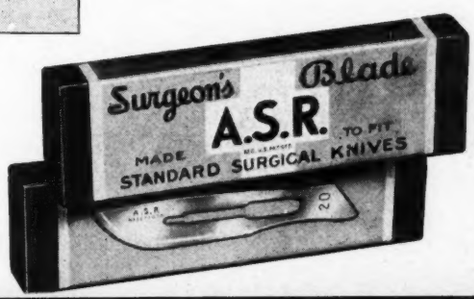
The coupon will bring you samples without charge. Simply check the types of blades you want. If you cannot purchase A.S.R. Surgeon's Blades locally, write direct to the American Safety Razor Corp., Surgeon's Blade Division, Brooklyn, N. Y.

QUANTITY PRICES

Less than 1 gross	$ 1.00 per dz.
From 1 to 4 23/24 grs.	11.40 per gr.
From 5 to 9 23/24 grs.	10.92 per gr.
From 10 grs. upward	10.56 per gr.

A.S.R.
REG. U.S. PAT. OFF.

FIT ALL STANDARD SURGICAL HANDLES —OLD OR NEW



American Safety Razor Corp.,
Surgeon's Blade Division, Dept. M-H-4,
Brooklyn, N. Y.

Kindly send me complimentary blades which I have checked.

[10] [11] [12] [15] [20] [21] [22] [23] [24]

Name.....

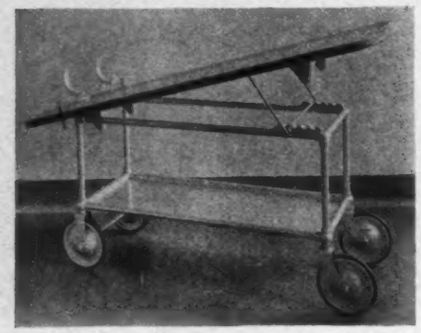
Street.....

City.....State.....

TRY THIS NEWLY DEVELOPED BLADE WITH OUR COMPLIMENTS

which we proved by various tests on sheets of metal. Acid and alcohol resistance was tested by sprinkling, immersion and staining, with various periods of time given for effects to appear. The products found by such tests to be the best were specified.

We designed what we consider an improved and simplified stretcher cart. This is built partly of aluminum and partly of steel tubing. We found that aluminum tubing when



The stretcher cart.

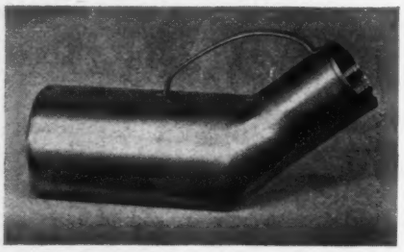
joined with threaded fittings was liable to break at the last inserted thread, especially when operators of carts would stand on the rails, therefore we turned to steel, but used aluminum for the removable stretcher top and the shelf underneath. We found that we could make these stretchers adaptable for spinal cases by merely attaching ratchet plates of cast aluminum to the frame, and an elevating bar at one end of the top, thus saving a large amount under the cost of the complicated and time consuming worm gear and pulley arrangements. For stretcher top cushions we found the rubberized hair in 3-inch thickness ideal and economical. We enclosed a pad of this material in a cover of old blanket material and rubber sheeting and believe that we have an almost everlasting pad from the standpoint of ordinary wear.

In specifying a pillow we consulted not only army and navy and other government specifications, but sought also the aid of the state bedding inspector. From his office we received much valuable advice and help, and after our orders had been placed he watched over the contractors to see that we got just what we had bargained for. This officer of the state is at your beck and call whenever you want his advice on your mattress or pillow problems.

We decided upon a duck feather pillow of 3 pounds weight, after learning from the literature on the subject of feathers that one must never expect a chicken feather or other land bird feather to resume its natural curl after washing or steaming; only aquatic fowl feathers will do that. We abandoned all consideration of chicken feathers and chose the quality known as "small curled gray body China duck." Our specification required not less than 10 per cent of down feathers and no flight feathers, quills or other débris. We found lively competition in this business and secured an excellent pillow at a reasonable cost. Had we insisted on white feathers of the same grade the cost would have been at least 400 per cent higher.

Consistently pursuing our policy of considering quality paramount in all purchases and measuring cost by units of service, or anticipated length of life, we decided upon rustless steel for all bedside and surgical utensils. We were convinced, after a review of the hospital's experience with porcelain enameled utensils over a number of years, that bedpans of rustless steel at $6 each would be cheaper than porcelain enameled pans at $1.50 each, and a rustless steel urinal at $4 cheaper than one of porcelain enameled steel at $0.75. Similar comparisons could be made as to solution basins, emesis basins, pitchers, canisters, catheter trays, dressing trays, in fact every item of metal ware used in the hospital and which heretofore has been obtained mainly in porcelain enameled steel. More than 7,500 utensils of the various types mentioned were purchased and were put into use about January 1, 1934. Up to October, 1935, not a single item out of this large quantity has had to be taken out of service for any reason whatsoever.

In the purchase of these utensils it was possible, because of the quantities ordered, to secure some important improvements. The standard bedpan was modified by making the front more straight in order to ensure more complete drainage in the bedpan washers. A urinal was designed



A specially designed urinal.

which can either be set on its bottom or laid on its side without spilling. On all items, the manufacturer was required to finish the edge with a "hem" instead of the ordinary rolled edge. The former is turned over and pressed close as if welded; the latter leaves an open groove underneath which is difficult to keep clean.

In kitchen utensils we have found cast aluminum satisfactory, but our experience with utensils formed of aluminum sheet or plate, sufficiently soft and pliable to permit of drawing and shaping, has not been favorable. The washing and sterilizing of these utensils two or three times daily, about five hundred of them being in use and speed being necessary to save both time and labor, has caused denting and distortion to such an extent that covers fit very badly and loss of heat results. The insulated double wall aluminum food containers which we had made for use on food carts will have to be replaced after two years of use, due to wear and failure to stand up under rough handling. They will be replaced with rustless steel containers of identical form which, on the basis of trials already conducted, we estimate will last at least ten years. The cost will be twice as much as the aluminum containers; the life at least five times as long. The work of keeping them clean will be simpler and less costly. Again, the higher price is the greater economy.[1, 2]

[1]Other equipment installed at Los Angeles County General Hospital was described in The MODERN HOSPITAL for July, 1934, and February, 1935.

[2]Read at the meeting of the American College of Surgeons, San Francisco.

Protecting Rubber Goods

With rubber goods playing so important a part in daily hospital routine, their care is of major importance and should be designed so as to prolong the life of the equipment and to ensure that it will be in readiness for future use. In order to accomplish this, the following precautions are suggested by Dr. G. Otis Whitecotton, administrative assistant, Alameda County Institutions, Oakland, Calif.:

1. Never place the equipment near radiator or in warming closet.
2. Never put it away folded, wrinkled, or with kinks.
3. Never put it away wet.
4. Always unfasten the clamps on the tubing when it is not in use and let it dry before putting it away.
5. Do not boil it longer than necessary and never boil hard rubber equipment.
6. When ice caps and hot water bottles are to be put away for a prolonged period, insert a small piece of gauze to keep the sides from coming into contact. When putting them away while in regular use, dry them thoroughly, inflate them with air and hang them on hooks.
7. Rubber sheets and pillow slips should be hung over a roller not less than one inch in diameter when not in use.

Name Engraved Thermometers

Now that some of the leading manufacturers are prepared to engrave on each thermometer the name of the hospital it should be easier to control this expense item. The addition of a serial number should make it still easier to identify these items and to control them after they are issued.

FOOD SERVICE • • • • •

Conducted by Anna E. Boller, Rush Medical College

The Summer Camp for Diabetic Children — An Extension of Hospital Service

By Henry J. John, M.D.
Cleveland

IT IS unfortunate that all the advantages of camp life have been denied to the diabetic child, whose very life is dependent upon special medical care, a restricted diet and the insulin syringe. These facilities are not available in the ordinary camp, and so the diabetic child has had to stay at home when his brothers and sisters and playmates have trooped off for a happy summer vacation.

The diabetic child especially needs the advantages of a vacation for the routine of everyday life becomes more burdensome to him than it does to the healthy person. He needs the benefit of open air and sunshine and the increased tone and vigor that come from strenuous exercise.

Then, too, a diabetic child has peculiar psychologic problems. He is likely to be introspective and to feel different and sorry for himself because of the restrictions and discipline that his disease places upon him. Even if the child himself would not be inclined toward this attitude of martyrdom, his fond and foolish parents may inflict it upon him through pity.

Let us review briefly some of the problems of the diabetic child. Fifteen years ago there were no such problems, for a child with diabetes was doomed to certain death. Then came insulin, and with it new life and hope for these unfortunate little ones. But this great boon brought with it special problems to the child, his parents and his physician. Health and happiness are not possible to the diabetic unless the strictest regimen of diet and medication and living habits is rigidly maintained.

The life of such a child is not easy. It means living always on a diet which, although adequate, is restricted. Those forays to the pantry in which all children revel must be strictly prohibited. It requires strength of character to be a good diabetic. These children learn moderation and self discipline very early in life. Only with these traits is life possible. A good diabetic is a normal individual in every way; a poor diabetic is a handicapped person who in time pays the penalty of his indulgence. It is not easy to remember the restrictions in a crowd or at school. There is much temptation, many a heartache, many an embarrassment. The diabetic has to learn to lift himself above all this and be stronger than those about him, if he is to be well.

If the child does discipline himself severely, a good state of health can be maintained, he can attain normal growth and can appear and act as a normal child who cannot be distinguished from his nondiabetic playmates. For the most part, the diabetic child outstrips his nondiabetic classmates in school and carries off

Mealtime on the porch during a vacation at the summer camp.

At Camp Ho Mita Koda there are three dietitians who plan proper diets for the diabetic children. In addition there is a very competent kitchen staff.

scholastic honors. This superior mental endowment has been noted by all physicians working in this field.

From the psychologic standpoint, it is easy for the child to be introspective, spoiled or the victim of a wrong attitude on the part of his parents. The introspective child, who is self-conscious about having diabetes, is likely to feel discouraged, to pity himself and to feel that there is not so much in store for him as for other children. Consequently he becomes morose and noncommunicative. The child who is spoiled usually is the only one in the family. He has been pampered and has had things his own way. At home he is the pivot around which all revolves and he grows completely selfish and self-centered.

The child who is a victim of his parents' attitude usually does not start out with an introspective attitude and inferiority complex. At first, he is happy and unconscious of the problem. He knows that he has certain things to do that other children do not do, that he has to deny himself some things, but what of it!

The parents, however, want sympathy for themselves. They have to care for the child, give him insulin and watch over him, and they want the whole world to know what a sacrifice they have to make. They talk to everyone about their difficulty. The topic of conversation with visitors always centers about the child's diabetes and what has to be done about it. Naturally visitors pity the child, pity the mother and before long the child begins to react to such an atmosphere. He begins to think that there is something very wrong with him, and when he keeps on hearing it, his attitude may reach the proportions of a pathologic state.

Surely such a child, who is highly endowed in spite of his handicaps, has a promising place in this world, offers an interesting medical problem, and deserves all the help we can give to make his struggle a bit easier.

The child's difficulties, however, represent only part of the problem. A small child with diabetes naturally cannot guide and control his own destiny. Someone else has to assume that responsibility for him. That someone is the mother. I often wonder, when these children grow up, whether they will ever fully realize what it has meant for their mothers to rear them.

A decade ago after the discovery of insulin had begun to preserve the lives of these little ones, we found mothers, tired, discouraged and worrying about the children, sacrificing their lives, and unable to be free of this arduous task, even for a day. I began to realize then that there was a double problem connected with the treatment of a diabetic child, the care of the child and the care of the mother. Once he was out of the hospital, the whole responsibility for the child's care was thrown on the mother, and there was no rest from it.

Reason for the Camp

Concern over this problem of the mother, as well as of the diabetic child, gave rise to the idea of a summer camp for diabetic children which would enable the mothers to shed the arduous responsibility for a month each year.

In the hospital, the solution of the problem of each individual diabetic patient is a technical problem which includes laboratory investigations, nursing and dietetic care and instruction. It is hospital care plus education; both are necessary.

A camp requires medical, nursing and dietetic supervision, plus a recreational organization, if it is to give the child what it should The camp and its activities come first. These must be in the foreground, but they must be supplemented by medical care. Although the latter is extremely important, it must be kept in the background, so far as the children are concerned. The emphasis must be on the play and activities and the medical regimen must be so organized that the children are scarcely conscious of its existence. Only in this manner can a camp for diabetic children function well and fulfill its mission.

To anyone acquainted with medical problems and the costs of medical care, it is obvious that the operation of such a camp is expensive. Two separate staffs are required—the medical and the recreational. Both are necessary and equally important. One without the other would result in failure.

Camp Ho Mita Koda, the camp for diabetic children near Cleveland, provides, besides the medical director, a resident staff physician, five nurses, three dietitians, men and women counselors, and junior counselors from the ranks of the diabetic children who have made good in camp in the past. In addition to these, a competent kitchen staff and general helpers are necessary.

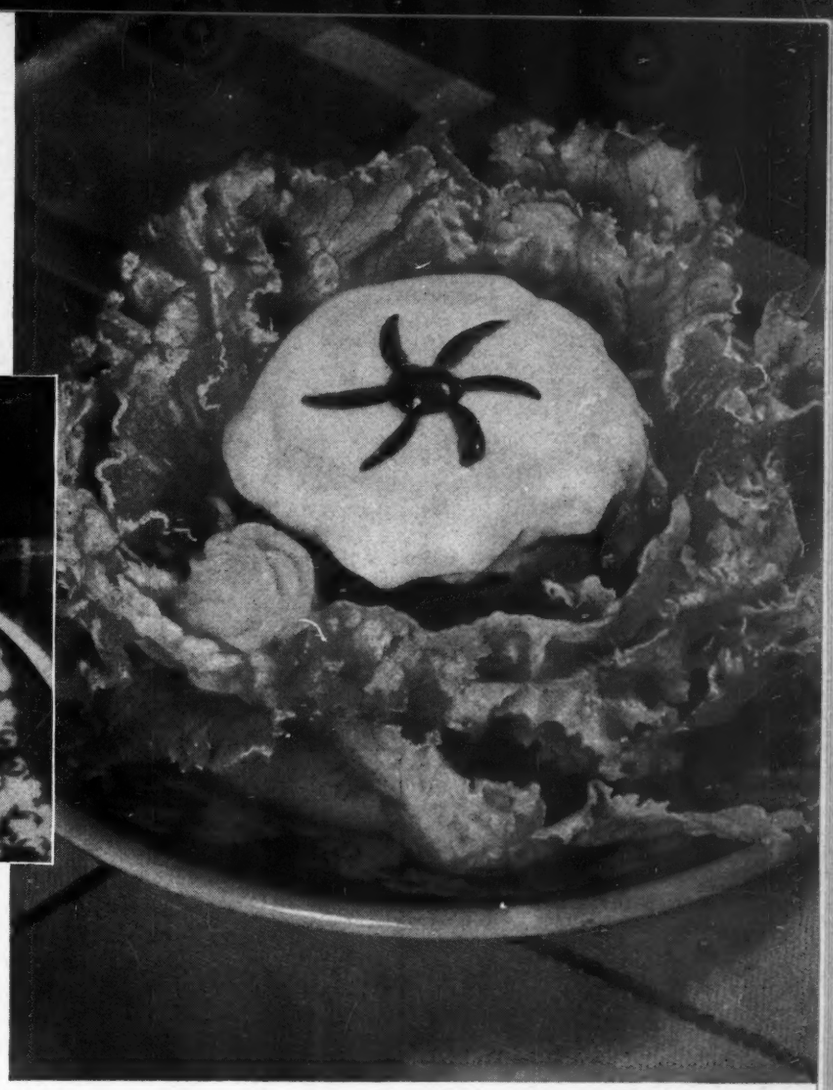
Camp Ho Mita Koda, which means in Sioux Indian "Welcome, my friend," is beautifully situated in the woods and well equipped. The "what to do" question for the children is intelligently answered by the efficient and expertly trained recreational staff, who understand young children and are devoting their lives to their service. These leaders have been chosen for their vision and sincerity. Each counselor is a specialist in his or her field.

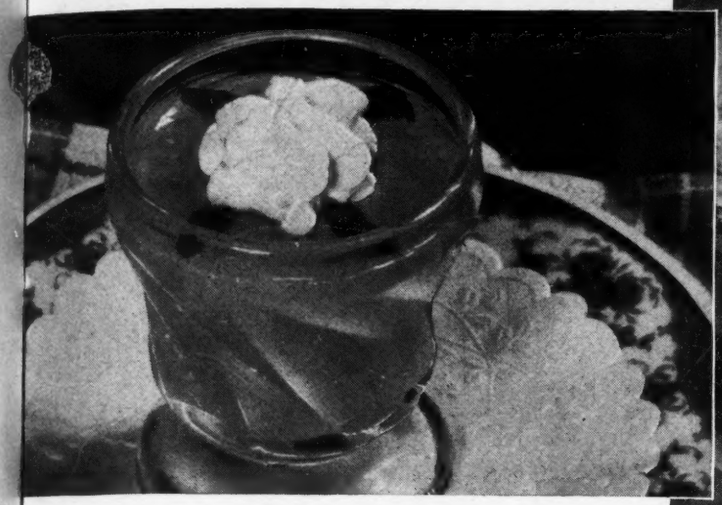
The children are grouped according to age under a leader particularly interested in the problems of that particular age group. They have much freedom, and the routine activities are planned to secure the cooperation and interest of the children. The camp gives the child at an early age the experience of being on his own, away from his parents. The example of the older children who are going to college or holding responsible positions as counselors stimulates the little ones to develop independence in the face of their handicaps.

In the camp, there are no extra fees for any of the privileges, craft materials or provisions. This eliminates class distinction in a group in which every class and every degree of each class are represented. No camper knows what his cabinmate's purse contains. There are no badges, cups or emblems as reward for prowess. All contests and games are played for the pure fun of playing. Winning is not so important as playing the game.

The institution is primarily a summer camp which constitutes a summer vacation for the children, and in ad-

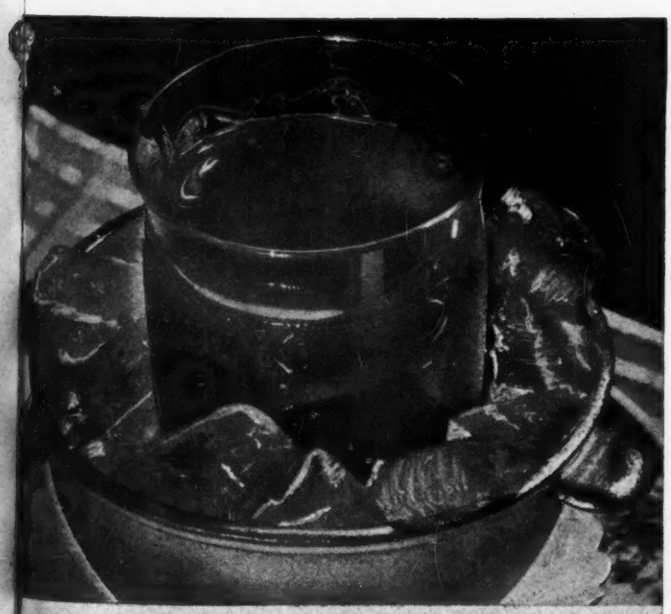
● **FOR HIGH CALORIC DIET**—*Two-tone Salad.* ¾ pkg. Philadelphia Cream Cheese, ¼ cup warm water, 1½ cups Libby's Pineapple Juice, 2 tbsps. lemon juice, 1 tbsp. gelatin, ¼ cup cold water, 2 tbsps. whipped cream, 2 tbsps. diced celery, 2 tbsps. chopped nuts, ⅓ cup diced orange. Dissolve gelatin in cold water. Add to heated pineapple juice and let cool. Add lemon juice. Cream Philadelphia Cream Cheese with the hot water; beat until smooth. Cool. Beat in whipped cream. Add ½ cup of above cooled pineapple mixture to the cooled cheese mixture and divide equally into four individual molds. Let set until firm. Add celery, nuts and orange to the pineapple mixture and pour over cheese mixture. When firmly set, invert molded salad on crisp lettuce and garnish with mayonnaise dressing. Serves 4.





● **FOR SOFT, LIGHT, GENERAL OR BASIC DIET**—*Pineapple Tapioca, St. Francis.* 1 cup Libby's Pineapple Juice, 2 tbsps. minute tapioca, 2 tsps. sugar, 1 tsp. lemon juice. Heat pineapple juice, add sugar and stir well. Bring to boiling point and gradually add tapioca into juice. Stir carefully. Cook over flame 5 minutes, then cook in double boiler until tapioca is transparent. Stir occasionally. Add lemon juice and pour into individual serving dish. Serve with whipped cream. Garnish with maraschino cherry. Serves 3.

"DISHES THAT COME BACK EMPTY"



● **PINEAPPLE-TOMATO JUICE COCKTAIL**—a new combination for diabetic, basic or liquid diet. Combine ½ cup Libby's Pineapple Juice with ¼ cup Libby's Tomato Juice (or 2 parts to 1). Pour into glass set in cracked ice. Serve cold. Serves 1.

● *These recipes were developed by Miss Esther Fisher, Chief Dietitian, St. Francis Hospital, San Francisco.*

Made with LIBBY'S Hawaiian Pineappl Juice—offering you full flavor and full tonic goodness

Zippy, tempting, original—the kind of dishes that help patie forget they ever lost their appetite.

You see, Libby's is just the natural, unsweetened juice of fr Hawaiian pineapples—with a tangy, deliciously invigorati flavor all its own.

And it retains full tonic goodness, because this juice is *up fresh.* It contains vitamin A, is a good source of B and C. supplies alkali-forming minerals and other needed values—uniform levels the year around. As a basis for *dishes that co back to the diet kitchen* empty Libby's Hawaiian Pineapple Ju is exceptionally versatile.

Get it from your usual source of supply. The cost is no higher than that of ordinary brands. Libby, McNeill & Libby, San Francisco.

Libby's 100 Fine Foods include Fruits and Fruit Juices, Vegetables, Pickles, Condiments, Canned Meats, Evaporated Milk, Alaska Salmon. Each comes in regular and special sizes for institutions. In addition, Libby packs Homogenized Foods for Babies

dition, it is an extension of hospital service. The children are watched and regulated as closely as they would be in a hospital. Proper diets planned by dietitians, nursing care and supervision, and laboratory tests enable the physician to guide and care for the children properly.

The diabetic child needs exercise which helps to metabolize the food. To a certain extent, this helps to replace insulin and the insulin dosage often can be reduced while the child is in camp. Play, hikes, tennis, volley ball, swimming—all these contribute to the improvement of the child's physical condition. Periods of rest help to refresh the energy and a good night's sleep in the fresh, woodsy air is different from that in the dusty, smoky atmosphere of the city. The regulated life, all on schedule, helps to form good habits and makes a definite change and impression on the child's mind, as well as his body.

The child who is surly and introspective sees the exuberant joy of life and the happiness of the other children around him. He begins to wonder whether he is as miserable as he thought. The others seem to be having a good time and enjoying life, and before he knows it, such a child plunges into the activities, forgets his own grief and tries to outdo the others. When this happens, his problem is solved and he is a different child.

The child who is spoiled and selfish finds that he is but one of a large body, and that he is not so different from the others. At first he misses being the focus of attention; later he despises being different. He does not want to be a sissy, he wants to be like the other fellows, and in an effort to compensate for his past defections, he is likely to outdo all the rest. Will such a child drift into his old habits when he returns home, or will he have a changed attitude? I believe that he will be different. This has been amply confirmed by mothers after the children return home.

The child who has been victimized by the wrong attitude of his parents gets, perhaps, the most benefit of all. The experience at camp rehabilitates him to his normal, healthy, happy state. He once more reacts to his situation in a rational way and thus gets a new lease on life that in a great many cases proves to be permanent.

Irradiated Vitamin D as an Antirachitic

By R. C. Buerki, M.D.
State of Wisconsin General Hospital, Madison, Wis.

GREAT advance has been made recently in our knowledge of nutrition as a preventive and curative agent and it is little wonder if the subject appears complicated. There are at least thirty-seven individual substances essential for a complete diet consisting of amino-acids (derived from proteins), essential fatty acids (derived from fats), dextrose, minerals and vitamins. An adequate supply of each of these substances is essential to life and health.

During the past ten years the world has become increasingly conscious of the vitamins. Perhaps no one vitamin has been singled out for such marked attention as vitamin D, for, although it was one of the last to be discovered, it was the first to be isolated in crystalline form.

The discovery of vitamin D brought to an end a long controversy, on whether rickets is a nutritional disease or a result of housing and poor hygiene. Both theories are in a sense correct. The former is a lack of vitamin D in the food; the latter a lack of sunshine to manufacture vitamin D in the body.

Bernheim[1] concludes, after clinical observations of 4,000 cases, that buoyant health follows the enriching of an ordinary diet with calcium and vitamins.

Calcium and phosphorus cannot be properly assimilated and utilized by the body without vitamin D as a mobilizing agent. Since Sherman and others have pointed out that a limited amount of calcium is supplied by the average American diet, an adequate intake of vitamin D is important for its fullest utilization.

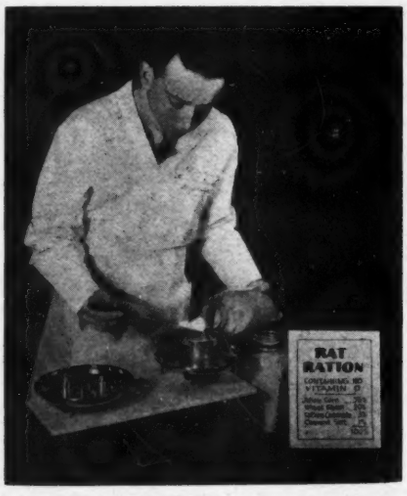
The Medical Research Council[2] has said that: ". . . the low intake of vitamin D may be the most important dietetic defect at present. While there is abundant proof that everyone would be better off with a greater intake of vitamin D, . . . its need is most evident during infancy."

The relationship of vitamin D to the prevention and cure of rickets is now universally recognized and accepted, but for more than 100 years, long before its cause was known, cod liver oil was used for this purpose. However, in view of the continued prevalence of rickets and other evidence of a lack of vitamin D, we can agree with Tisdall[3] that, "it is apparent that fish oils and viosterol as administered in the past has not fully met the situation." We need some universal method of administering vitamin D in an acceptable, economical manner.

This need to introduce vitamin D into the human system through some other means led to a discovery which is now history. The knowledge that

Laboratory animals are standardized as to strain, breed, age, weight, and in other ways in order to assure uniformity of reactions when making tests.

the sterols, particularly ergosterol and cholesterol, are some of the chemical precursors of vitamin D is the outcome of the laboratory discovery that rickets can be prevented and cured in young rats by exposure to ultraviolet light or strong sunlight. Continuing along this line almost simultaneously, Dr. Harry Steenbock of the University of Wisconsin and Dr. Alfred F. Hess in New York City found that many natural foods which have no antirachitic properties can be given such properties by suitable exposure to ultraviolet ray light. It was as a result of this work that irradiated ergosterol, called by the name of viosterol, and other irradiated pharmaceuticals came into use for the actual prevention and treatment of rickets. This use of irradiation is controlled by the Wisconsin Alumni Research Foundation and the funds



A pre-determined diet is used to produce rickets in the laboratory animals. The diets are standardized to produce a standard condition of rickets.

TAKE A QUICK LOOK, DOCTOR!

Here, in brief, are important advantages you'll want to remember about Ralston Wheat Cereal

A WHOLE WHEAT CEREAL

Choice whole wheat, with only coarsest bran removed is used in preparing Ralston. That means, of course, that Ralston provides in abundance all the body-building, energy-producing elements which make whole wheat one of our most important cereal foods.

DOUBLE-RICH IN VITAMIN B

Pure wheat germ is added to Ralston, making it 2½ times richer in vitamin B than natural whole wheat. The value of such a "double-rich" cereal as an aid to keeping appetites normally eager, promoting growth and general well-being, is evident to any director of diets.

DELICIOUSLY PALATABLE

The natural goodness of choice whole wheat gives Ralston a wholesome, hearty flavor that is equally popular with children and adults.

CONVENIENT AND ECONOMICAL

Ralston cooks quickly, and is ready to serve just as it comes from the pan. Moreover, each generous serving costs only about one-half a cent. For a Research Laboratory Report and samples of Ralston, the "double-rich" wheat cereal, use the coupon below.

Ralston Purina Company,
Dept. MH 138 Checkerboard Square, Saint Louis, Missouri

Please send me a copy of your Research Laboratory Report and samples of "double-rich" Ralston Wheat Cereal.

Name_____

Address_____

This offer limited to residents of the United States

derived from it are used for scientific research.

Long and expensive clinical tests, first with thousands of laboratory animals and then with humans, have demonstrated that foods fortified with vitamin D, if given regularly and in sufficient amounts, are equally if not more satisfactory than drugs. This applies particularly to milk, either fluid or evaporated. Irradiated milks are inexpensive and contain calcium and phosphorus in the right ratio and in the right amounts, easily and completely available for the body's use.

A mass of scientific literature has accumulated on the value of both foods and pharmaceuticals reenforced with vitamin D by means of irradiation.

Dr. Alfred F. Hess[4] reports from a clinical test carried on during two winters in a baby health clinic of the department of health in New York: "It was established unequivocally that irradiated milk is able to prevent rickets almost without exception. Indeed, it prevented the development of this disorder in Negro infants, who are exceptionally susceptible. It should be added that the majority of these infants were under six months of age and received three-quarters, rather than an entire quart of milk daily."

Further, he says: " . . . It is increasingly evident, from a communal standpoint, the best method of preventing rickets involves the use of some form of antirachitic milk, and furthermore, that we must draw a distinction between measures which are most suitable for the prevention and those most suitable for the cure of rickets. . . . In addition, milk has the distinction and advantage of being the food which contains calcium and phosphorus in the highest degree.

". . . Activated milk, in the fluid or dry form, possesses the advantages, not only of providing an automatic method of preventing rickets and of supplying this essential factor in a medium rich in phosphorus and calcium, but, as has been shown, it accomplishes this end by means of an exceptionally small amount of the antirachitic factor. In view of these important advantages, I do not hesitate to recommend the general use of such milk for infants and children, especially in large communities."

Drake, Tisdall and Brown[5] in an effort to establish the relative antirachitic value of cod liver oil, viosterol and irradiated milk, report a study on 529 Toronto infants, largely of British and Northern European descent, made under home conditions over a period of five winter months. The ages of the infants at the initial examination varied from three weeks to eight months. These workers used x-ray examinations as their best means of diagnosing rickets, placing little or no reliance on the usually accepted clinical signs, craniotabes, rosary, or slight enlargement of the epiphysis.

Their results would not indicate that "Toronto sunshine, as at present used, is entirely efficacious in preventing x-ray evidence of rickets, since 12.8 per cent of 349 infants examined in October showed very slight rickets, and 4.5 per cent mild rickets. No infants, however, showed moderate or marked rickets." These workers felt that infants under four months of age in October are more apt to develop rickets in the succeeding five winter months than are infants from four to eight months of age in October.

One, 2, or 3 teaspoonfuls of cod liver oil were prescribed for 137 Toronto infants. Of these, 3 infants developed moderate or marked rickets during a period of five months probably due to difficulties encountered in the administration of cod liver oil under home conditions. The results of these observations indicate that 1 teaspoonful of cod liver oil was at least as efficacious as 3 teaspoonfuls in the prevention of rickets, as evidenced by x-rays.

One hundred, 200, 400 and 800 Steenbock vitamin D units, in the form of viosterol (1.5 to 12 drops of 250 D viosterol), were prescribed for 186 Toronto infants. Under these conditions no infants developed moderate or marked rickets during a period of five winter months. One hundred, 200, 400 and 800 units, in the form of viosterol (from 1.5 to 12 drops of 250 D viosterol), were efficacious in the same degree in the prevention of rickets, as evidenced by x-rays.

From 20 to 40 ounces of irradiated vitamin D milk, containing 35 Steenbock vitamin D units, per 20 ounces, were prescribed to 141 Toronto infants, ranging in age at initial examination from 3 weeks to 8 months. The milk was administered over a period of five winter months. Under these conditions, no infants developed moderate or marked rickets.

Still later work on Negro infants, reported by Rapoport, Stokes and Whipple[6] indicates that irradiated evaporated milk is an adequate preventive of rickets but unreliable as a curative agent.

The question of overdosage when vitamin D is received from several sources seems to be the one most frequently raised. A review of the literature warrants the conclusion of a negative answer to the question.

An editorial from the *Journal of the American Medical Association*[7] says: "There is evidently an enormous range of safety between prophylactic or therapeutic dosage and the quantities that are likely to do harm. The toxic dose is probably 1,000 times the therapeutic dose of viosterol."

This statement is corroborated by evidence from many studies. Clouse[8] found that in short-time experiments disastrous results were not apparent until the dose reached 25,000 to 50,000 times the minimum antirachitic dose. Tisdall[3], McCollum, Reed and his associates[9], Kramer, Grayzel and Shear[10], Shelling and Hopper[12], Hauch[13], Coffin[11], Wechel[14], MacKenzie[15], Lewis[16], Watson[17], a committee of the New York Academy of Medicine[18] and Fishbein[19] have all given evidence indicating that the damage of overdosage is so remote that it may be disregarded entirely in considering irradiated foods. Wechel, for example, declares that at least 100 quarts of irradiated

RECIPES BY REQUEST

Submitted by

Nell Taylor Wolfe
Michael Reese Hospital, Chicago

•

Mushrooms Stuffed With Ham (20 servings)

1 cup finely minced mushroom stems
1 small onion finely minced
½ cup chicken fat
2 cups minced ham
2 tablespoons flour
1 cup chicken broth
3 tablespoons soy sauce
¾ cup cracker meal
3 egg whites
Parmesan cheese

Sauté onion and mushroom stems in chicken fat for 10 minutes. Add flour, then chicken broth. Work smooth, allowing to cook 5 minutes longer. Add ham, cracker meal and soy sauce. Mix well and allow to cool. Beat egg whites until stiff, fold into mixture. Fill large mushrooms with mixture and steam for 10 minutes. Before serving sprinkle with Parmesan cheese and brown.

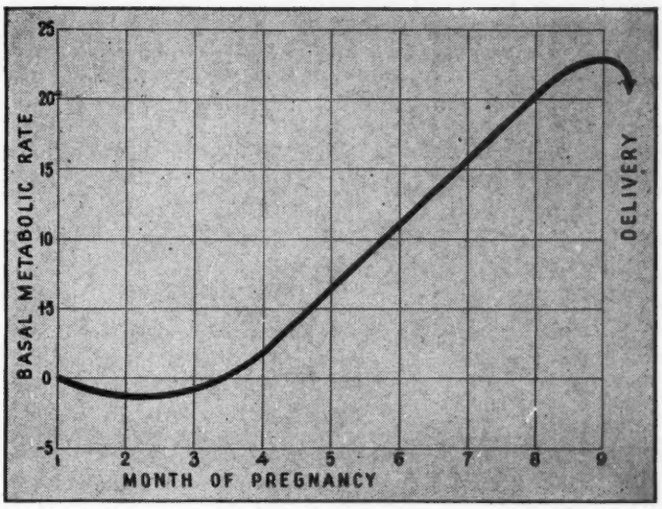
•

Giblet Soup

2 tablespoons fat
1 onion sliced
2 pounds meat and bones
⅓ cup diced carrots
⅓ cup diced turnips
⅓ cup diced celery
3 quarts cold water
1 tablespoon salt
½ teaspoon pepper
Giblets from 3 chickens

Cut meat in small pieces and crack the bone. Melt fat in soup kettle, brown onion in it, then add meat, brown slightly and remove from kettle. Brown the vegetables in the same fat and remove from kettle. Add the meat, bone, water, salt and pepper, bring to boiling point and boil thirty minutes. Remove scum instantly if it forms, add vegetables; cook slowly one hour longer, strain through double cheese cloth and clarify if necessary in order to get a clear brown stock. Chop the giblets and pan-fry them for about ten minutes. Add to the brown stock and let simmer for one hour before serving. Makes 2½ quarts.

PROTECTING THE EXPECTANT MOTHER



NORMAL PREGNANCY has its disturbances. During the first half of pregnancy the woman's metabolic rate is not changed. After the fourth month it gradually increases to 23% above her norm. Caloric increase in the diet is thus necessary after the fourth month.

But vomiting of pregnancy interferes! The condition is looked upon today as a disturbance in carbohydrate metabolism. Upon this assumption is based the present-day treatment by carbohydrate diet. The early introduction of small carbohydrate meals at 3 hour intervals helps prevent this disturbance. Karo added to foods and fluids prevents glycogen depletion and ketosis.

The enlarging of the uterus further produces reflex vomiting and unless carbohydrate is taken throughout the day to maintain the blood sugar at a high level, ketosis results. This aggravates the vomiting, frequently beyond control, because of the inability of the damaged liver in pregnancy to resist ketosis. Karo helps provide the expectant mother with readily assimilated sugars preventive of ketosis. Karo consists of dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor), not readily fermentable, rapidly absorbed and effectively utilized.

ACCEPTED
AMERICAN MEDICAL ASSN.
Committee on Foods

Corn Products Consulting Service for Physicians is available for further clinical information regarding Karo. Please Address: Corn Products Sales Company, Dept.H-2, 17 Battery Place, New York City.

milk a day would be necessary to approach a toxic condition from an overdose of vitamin D.

Vitamin D is so necessary for the welfare of infants that we are apt to overlook the fact that older children and adults require it too. Its greatest importance is no doubt during rapid growth, but as a *Journal of the American Medical Association* editorial states: "A liberal supply of mineral elements and an adequate allowance of vitamin D at every stage of life is important."

At no time during adult life is the need for vitamin D greater than during pregnancy. The calcification of the bones of the fetus during the later months of gestation and the calcification of the teeth cannot take place, at least with safety to the mother unless she reserves and utilizes an abundant amount of calcium and phosphorus.

From Schlutz[20] we have the statement: "With recent knowledge of the action of light and its faculty to make available vitamin D through irradiation and photochemical activation, the possibility of favorably affecting calcium and phosphorus balances in the pregnant and lactating female through this procedure, in addition to the use of high vitamin D containing foods and substances, has been thought of. In the human fetus the elements are stored from about the fourth month on. The storage, which begins slowly at first, becomes more rapid toward the end of pregnancy. About two-thirds of the total amount stored at birth is stored during the last two months of pregnancy. The amount of calcium and phosphorus stored by the mother during gestation varies considerably. Sometimes it is well above the supposed fetal demand. Again, it may be considerably below. This is especially true of calcium. In such cases the mother is either taking the elements from her own tissues or the fetus is getting an insufficient supply."

The relationship of rickets to pregnancy is further emphasized by Hess[21] who states that, "many operative procedures incident to childbirth, which lead to the death or injury of mother or infant, are properly attributable to rachitic deformities of the pelvis."

James Fenton[22] writes: "In addition to its proved great value in the treatment of rickets and allied disorders, there are many indications of its value in other disorders. In the management of pregnancy, in lactation, in the correction of dental caries, and as a special source of energy in many disorders of nutrition, irradiated milk has proved its value. In some of these conditions, there is a defect in the nutrition of calcium and phosphorus, which is corrected by the use of milk."

Similar statements have been made by the committee on nutritional problems of the American Public Health Association[23], Tisdall[3], Clouse[24] and Schlutz[20].

In answer to the question, "Should adults get vitamin D?" McCollum[25] states: "The question is now frequently asked of me whether adults should take a source of vitamin D as a safeguard to physiological well-being? The only logical answer in the light of the available evidence is that there is little room for doubt that an additional source of the vitamin . . . affords a safeguard for health."

While it is true that the amount of vitamin D necessary for adults has not been definitely established, still the prevalence of dental decay indicates the importance of nutrition to the health of the teeth. The latter subject has been extensively studied by Dr. May Mellanby[26] of England. An extensive discussion of her work has been published by Dr. Edward Mellanby[27].

Conclusions

1. Irradiated foods and pharmaceuticals are effective antirachitics. Irradiated milks are particularly efficacious along this line.

2. There is no danger of overdosage of vitamin D resulting from taking foods reenforced with vitamin D by means of irradiation.

3. Vitamin D, while essential for infants, is equally important for older children. Adults require it, too.

4. At no time during adult life is the need for vitamin D greater than during pregnancy and lactation.

Bibliography

1. Bernheim, J. A. M. A., 100:1001, 1933.
2. Vitamins: A Survey of Present Knowledge, Special Report Series No. 167, Medical Research Council, Great Britain, 1932, p. 48.
3. Tisdall, Am. J. Dis. Child., 45:619, March 1933.
4. Hess, Am. J. Pub. Health, 22:1215, Dec. 1932.
5. Drake, Tisdall and Brown, Canad. M. A. J., 31:368, Oct. 1934.
6. Rapoport, Stokes and Whipple, J. Ped., 6:799, June 1935.
7. The Action of Vitamin D, J. A. M. A., 97:105, July 1931.
8. Clouse, J. A. M. A., July 16, 1932 (215).
9. Reed, J. A. M. A., 102:1745, 1934. Arch. Phys. Ther., X-Ray, Radium, 16:537, Sept. 1935.
10. Kramer, Grayzel and Shear, Proc. Soc. Exper. Biol. and Med. 27:144, Nov. 1929.
11. Coffin, J. Am. Dietet. A., 11:119, July 1935.
12. Shelling and Hopper, Am. J. Dis. Child., 47:61, Jan. 1934.
13. Hauch, J. Nutrition, 8:163, Aug. 1934.
14. Wechel, Presented before the Chicago Dairy Technology Society, Nov. 14, 1933.
15. MacKenzie, Northwest Med., 33:22, Jan. 1934.
16. Lewis, New York State J. Med., 34:685, Aug. 1934.
17. Watson, Certified Milk, 6:1, Apr. 1931.
18. Committee on Public Health Relations Bull. New York Acad. Med. 10:507, Aug. 1934.
19. Fishbein, J. A. M. A., 97:85, July 1931.
20. Schlutz, J. A. M. A., 99:384, July 1932.
21. Hess, Ricketts (Osteomalacia and Tentanus), 18-19, 1929.
22. Fenton, Am. J. Pub. Health, 21:1339, Dec. 1931.
23. Am. Pub. Health Assn. Year Book, New York, 1933.
24. Clouse, J. A. M. A., 99:215, July 1932.
25. McCollum, Med. Searchlight and Science Bull., 8: Jan. 1932.
26. Mellanby, M., Brit. M. J., 2:354, 1924 and Med. Res. Council, Great Britain, No. 140, 1929. Brit. M. J., 2:1079. Dec. 1928.
27. Mellanby, E., J. A. M., 96:329, 1931.

FOOD FOR THOUGHT

• For some time irradiated milk has been the cause of much discussion. A new development along this line which seems successful is measuring the amount of vitamin D which has been formed in the milk. Dr. C. Rentscheer of the Westinghouse Research Laboratories has just completed some work along this line. This will be a great advantage for those depending upon milk for the source of vitamin D, as it will take the guesswork out of planning diets with this in mind.

• So many dietitians have requested recipes for some of the unusual dishes listed in the menus during the past two years that we have decided to publish several of these each month, as a new feature of the department. The first two recipes appear this month.

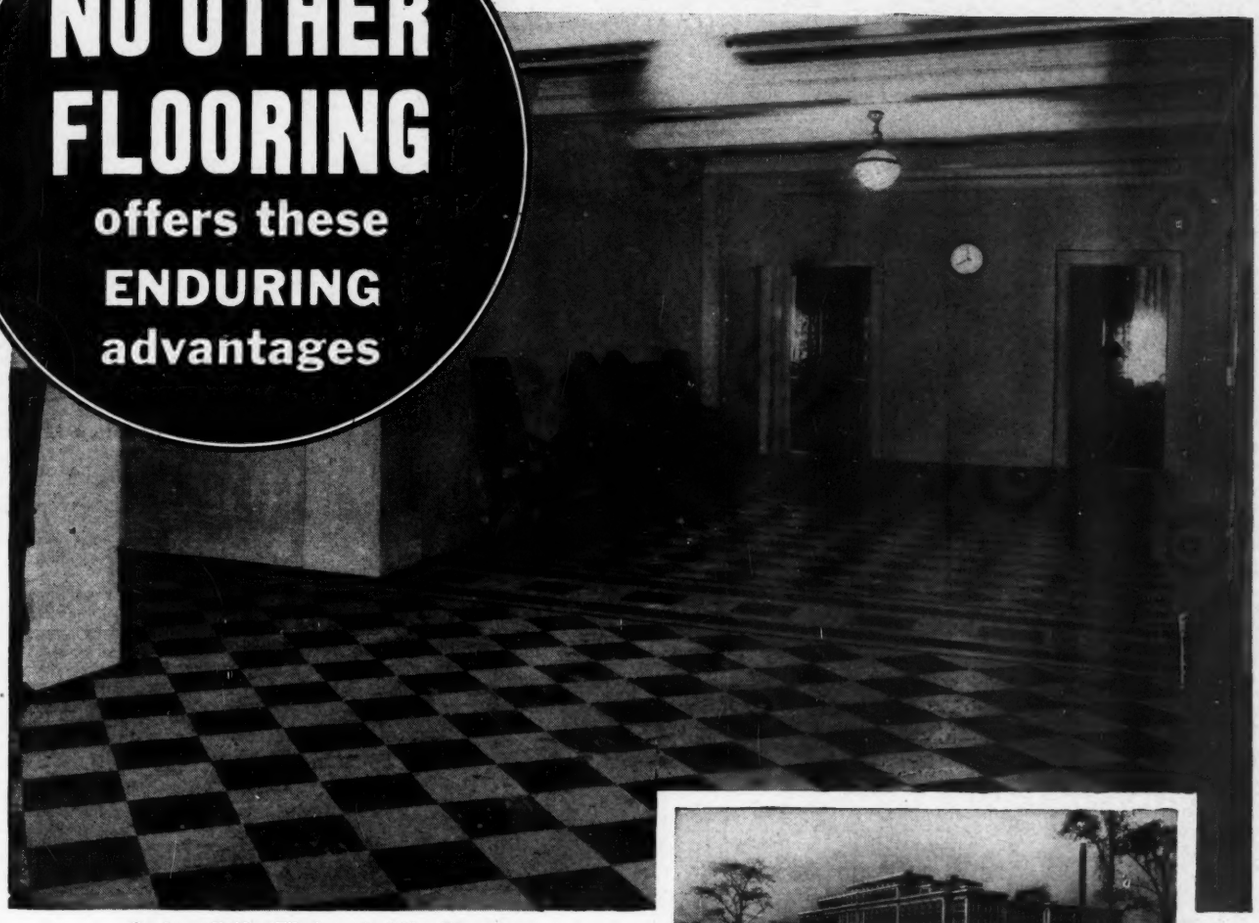
• No doubt you have had some of your diabetic patients bring in clippings from the daily newspapers in regard to a "new treatment for diabetes." If you haven't seen the original articles which appeared in the *Journal of the American Medical Association* for January 18 you may be interested in the abstracts on page 120 of the two articles by the Copenhagen doctors who discovered this new substance—protamine insulinate—and also the Boston investigators who have tried it clinically. All dietitians will want to know about this new substance as the Boston investigators suggest that it may revolutionize the treatment of diabetes.

• Those who haven't seen the bibliography prepared by the administrative section of the American Dietetic Association will certainly want to get a copy of it. It covers all phases of administration, food, equipment, personnel, furnishings, building, and will be of value not only to the dietitian but to the housekeeper as well. These are available for a few cents from the office of the association.

• At the recent meeting of the Home Economics Association in Chicago, two workers from the University of Oklahoma, Emma L. Bond and Helen B. Burton, reported that persons sensitive to wheat protein may find that sorghum bread will help round out their diets. The grains that they used in their experimental work were millo and black hull kaffir corn, which can be made into biscuits, muffins and steamed bread.

• An unusual piece of equipment has been put on the market fairly recently. It is an adaptation of the old steam cooker and range. Several hospitals who have been using it, have commented favorably on this type of equipment, as, in combining two pieces of this type, it seems that there might be a great saving of space.

NO OTHER FLOORING offers these ENDURING advantages



Goodyear Rubber Tile in main lobby, Youngstown Hospital, Youngstown, Ohio—Architect Albert Kahn

GOOD looks were not the only reason for the installation of Goodyear Rubber Tile in the Youngstown Hospital. Long experience proves that it excels other floorings in hospital service in these important respects:

DURABILITY—*Goodyear Rubber Tile makes a long-wearing floor that will withstand heaviest traffic for many years.*

CLEANLINESS—*it is impervious to dirt. A damp mop keeps it spotless.*

FIRE—AND STAIN-PROOF—*it is not marred by burning cigarettes or matches, nor stained by most acids, ink, etc.*

QUIET—*its resiliency minimizes noise and insures maximum comfort underfoot.*

BEAUTIFUL—*rich two and three tone permanent colors.*

STYLE—*wide choice of colors and designs, adaptable to any interior plan.*

Made in individual blocks in a wide range of colors and sizes, applied in any desired pattern, Goodyear Rubber Tile is a quality floor that will endure and require practically no maintenance other than cleaning. Its many advantages are also available today, at less cost, in Goodyear Wingfoot Sheet Rubber Flooring—made in continuous lengths like linoleum and laid in the same manner. For further information, write Goodyear, Akron, Ohio, or Los Angeles, California.

Complete specification data in Sweet's Architectural Catalogue

THE GREATEST NAME IN RUBBER

GOODYEAR

RUBBER FLOORING

March Dinner Menus for the Staff*

By Frances Berkeley Floore
Director of Dietetics, St. Luke's Hospital, Chicago

Day	Meat or Substitute	Potato or Substitute	Vegetable	Salad or Relish	Dessert
1.	Fried Chicken, Country Gravy	Mashed Potatoes	Stewed Tomatoes	Pear and Cream Cheese Salad	Fudge Sundae
2.	Smothered Liver	Escalloped Potatoes	Buttered Peas	Head Lettuce, French Dressing	Lemon Chiffon Pie
3.	Roast Pork	Candied Sweet Potatoes	Creamed Asparagus	Celery and Olives	Baked Apple With Whipped Cream
4.	Lamb Chop, Mint Sauce	Baked Potatoes	Spinach au Gratin	Molded Cucumber and Pineapple Salad	Caramel Custard
5.	Beef Stew and Baking Powder Biscuits	Rice	Carrots and Peas	Applesauce	Pineapple Bavarian Cream
6.	Escalloped Oysters	French Fried Potatoes	Wax Beans	Chicory, French Dressing	Peppermint Ice Cream
7.	Veal Cutlet, Tomato Sauce	Stuffed Potatoes	Creamed Onions	Prunes Stuffed With Cream Cheese	Devil's Food Cake
8.	Roast Duck With Dressing	Browned Potatoes	Baked Hubbard Squash	French Endive With Orange	Banana Cream Pie
9.	Fillet of Sole, Tartare Sauce	Mashed Potatoes	Lima Beans	Celery Cabbage	Praline Ice Cream
10.	Chicken à la King	Baked Noodles	Mustard Greens	Tomato, Mayonaise	Rhubarb and Cookies
11.	Baked Ham With Pineapple Ring	Baked Sweet Potatoes	Harvard Beets	Leaf Lettuce, French Dressing	Raspberry Gelatin With Whipped Cream
12.	Corned Beef	Parsley Butter Potatoes	Cabbage	Waldorf Salad	Washington Cream Cake
13.	Salmon Loaf	Escalloped Potatoes	Broccoli, Hollandaise Sauce	Cottage Cheese and Chives	Chocolate Meringue Pie
14.	Veal Birds	Mashed Potatoes	Creamed Mushrooms	French Endive and Romaine	Caramel Eclairs
15.	Steak	French Fried Potatoes	Parsnips	Tomato Juice, Celery and Pickles	Marshmallow Nut Sundae
16.	Roast Lamb, Mint Jelly	Browned Potatoes	Julienne Carrots	Head Lettuce, Roquefort Dressing	Prune Whip
17.	Egg Cutlets, Tomato Sauce	Baked Potatoes	Succotash	Olives and Pickles	Blueberry Gelatin and Whipped Cream
18.	Pot Roast	Long Branch Potatoes	Okra and Tomatoes	Piccalilli	Grapefruit Halves
19.	Lamb Stew and Baking Powder Biscuits		Onions, Peas and Carrots	Fruit Salad, Sherry Dressing	Pineapple Sherbet
20.	Fried Oysters, Lemon Slices	Creamed Potatoes With Pimiento	Spinach	Coleslaw	Neapolitan Slices
21.	Pork Chop	Rice au Gratin	String Beans	Cinnamon Apple Salad	Caramel Nut Pudding
22.	Chicken à la Marengo	Mashed Potatoes	Hubbard Squash	Romaine, French Dressing	Strawberry Sundae
23.	Meat Balls	Italian Spaghetti	Buttered Cauliflower	Radishes and Celery	Cherry Tarts With Whipped Cream
24.	Baked Ham With Crabapples	Candied Sweet Potatoes	Mustard Greens, Hard Boiled Eggs	Tomato and Chicory Salad	Lemon Gelatin and Marguerites
25.	Smothered Steak	Parsley Butter Potatoes	Wax Beans	Asparagus Salad	Jelly Roll
26.	Stuffed Lamb Chops	Baked Potatoes	Creamed Celery	Red Cabbage and Green Peppers	Chocolate Ice Cream
27.	Broiled Lake Trout	Escalloped Potatoes	Peas	Molded Cucumber, Pineapple and Celery Salad	Rhubard Pie
28.	Chop Suey With Chinese Sprouts	Fried Noodles		Combination Salad, Roquefort Dressing	Apple Dumpling, Lemon Sauce
29.	Chicken Fricassée	Rice	Spinach à la Béchamel	Escarole, French Dressing	Charlotte Russe
30.	Roast Beef, Horseradish Sauce	Browned Potatoes	Stewed Tomatoes	Ripe Olives and Celery	Grape Ice
31.	Sausage Cakes	Mashed Potatoes	Sauerkraut	Head Lettuce, Sherry Dressing	Pumpkin Pie

*Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, THE MODERN HOSPITAL, Chicago.

NEWS IN REVIEW • • • •

Syracuse, N. Y., Norwalk, Conn., and Alabama Organize New Group Hospitalization Plans

Three new group hospitalization plans have recently been organized, one in Syracuse, N. Y., another at Norwalk, Conn., and a third, a statewide plan, in Alabama.

The Syracuse plan, announced in January, is administered by Syracuse Hospital Service, Incorporated, a nonprofit corporation formed under New York's group hospitalization law. The officers and directors of the corporation are prominent Syracuse business people and hospital trustees. Carl P. Wright, superintendent, General Hospital of Syracuse, is the only hospital administrator on the board.

Robert Parnall is managing director for the corporation. He is also director of the group hospitalization organization at Geneva, N. Y.

The five general hospitals of Syracuse which are approved by the American College of Surgeons are cooperating in the plan. These hospitals are: Crouse-Irving Hospital, General Hospital of Syracuse, Hospital of the Good Shepherd, St. Joseph Hospital and Syracuse Memorial Hospital.

The plan provides that men and women under sixty-five years of age and employed by the same firm may subscribe in groups of ten or more. Hospitalization up to twenty-one days in any one membership year is provided in semiprivate accommodations. The cost is 15 cents a week.

Alabama Plan Covers State

Formal announcement of the Alabama plan has not yet been made but an organization meeting was held in Birmingham on December 27. By January 13 a total of twelve hospitals had agreed to join the corporation but the charter membership was being held open to permit others to come in during the month.

The Alabama interhospital contract, in addition to the usual terms, provides that hospitals shall be paid at the rates of $4 and $6.50 per day for ward and private room service, respectively, to subscribers. The contract is an entirely mutual affair and the hospitals agree to meet any deficit that might be involved in the liquidation of the Hospital Service Corporation of Alabama.

An unusual feature of the Alabama law on group hospitalization requires that any hospitals entering the plan must first be approved by both the Alabama Hospital Association and the Medical Association of the State of Alabama. No memberships will be sold in any county without the consent of the board of censors of the county medical society.

The board of trustees of the corporation is composed of representatives of the member hospitals, one from each hospital. Working capital is to be obtained through an assessment of $2 per bed on each hospital.

Two types of contracts are proposed, a Class A contract for ward service at $9 a year and a Class B contract for private room service at $18 a year. Family members may be covered in the Class A contract by paying $0.50 a month additional for a wife, $0.85 a month additional for a wife and children under eighteen, and $0.50 a month for any other dependent person. For the Class B contract the rates for family members are the same except that the group rate for a wife and all dependent children under eighteen is $1.50 a month.

Business Men Interested

The third plan, started in Norwalk, Conn., on January 13, provides twenty-one days of semiprivate care for a $9 annual fee. X-ray, laboratory and operating room service are included and delivery service after a ten-months' membership. A discount of one-third from regular hospital rates is granted after the expiration of the twenty-one day period.

The Norwalk plan is administered by Hospital Service Plan, Inc., a nonprofit corporation whose officers and directors are prominent business men of Norwalk. Kenneth M. Coleburn is executive secretary of the corporation and Robert N. Brough, superintendent of the Norwalk Community Hospital, is secretary. Since there is only one hospital in Norwalk most of the service will be rendered there but subscribers who are traveling outside of Fairfield County may receive the benefits in any hospital in case of accident or emergency illness. Family members may also enroll at the same rates as employed persons.

The plan has been well received by the leading business men of Norwalk and by the medical profession, according to Mr. Brough, although he adds that it is as yet too early to predict the ultimate enrollment.

United Hospital Fund Yearbook Outlines Plans

Details of the reorganization of the United Hospital Fund of New York City are contained in the fifty-sixth yearbook of the fund which has recently been published. The by-laws of the fund have been revised to permit the inclusion of every hospital in the city rendering a needed community service, an impartial distributing committee has been set up to distribute funds partly on the basis of free service and partly according to community needs, a women's division has been organized to coordinate women's work in the various hospitals and to give the women's auxiliaries a voice in the work of the fund.

In addition the fund is developing and rounding out its service departments, has promoted the hospital survey for New York, and has sponsored group hospitalization.

These various developments lay the foundation, in the opinion of David H. McAlpin Pyle, president, for a broad community appeal to provide funds so that hospitals will not have to pyramid deficits.

Expands Research Laboratories

Extension of the diagnostic and research laboratories of the Neurological Institute in New York City is under way. The thirteenth and fourteenth floors of this building, which is part of the Columbia-Presbyterian Medical Center, formerly used for the housing of nurses is being converted to this purpose. Ralph Pomerance is the architect with Charles F. Neergaard as consultant. The institute has appointed Dr. Nolan E. T. Lewis assistant director in charge of clinical and clinico-pathologic research. Doctor Lewis has been director of laboratories at St. Elizabeth's Hospital, Washington, D. C., since 1919. He is also field representative and coordinator of research in dementia praecox, financed by the Supreme Council of 33 Degree Northern Masonic Jurisdiction, directed by the National Committee for Mental Hygiene.

Group Plan Progresses

Group hospitalization is developing rapidly in Washington, D. C. The plan was started there in July, 1934, and had enrolled 2,006 employed people by October of that year. In the succeeding twelve months the enrollment rose to 15,898, according to a recent statement from the administrative officer of the plan. There is an enrollment fee of $1 and dues of $0.75 a month. The benefits follow the traditional pattern except that x-ray service is not included.

New York Hospital Group Discusses Dietetic Problems at January Meeting

A discussion of the problem of conducting an efficient food service at moderate cost attracted a large gathering of dietitians and hospital executives at a special joint meeting of the Hospital Conference of the City of New York and the Greater New York Dietetic Association held January 10 in Blumenthal Auditorium, Mount Sinai Hospital, New York City, with Dr. E. M. Bluestone, superintendent, Montefiore Hospital for Chronic Diseases and president of the Hospital Conference, presiding.

Much of the interest centered upon the results of a dietary survey of hospitals throughout New York State, which has just been completed by Dr. Mary deGarmo Bryan, head of Institution Management, Teachers College, Columbia University. Doctor Bryan's report was submitted by Lenna F. Cooper, dietitian of Montefiore Hospital. This survey embodies the suggestion that a bill be presented to the state legislature proposing that all state institutions be required to employ dietitians who meet with the approval of the American Dietetic Association.

Due to the fact that many hospitals report lack of funds as a reason for not employing dietitians, it is suggested that two or three hospitals centrally located employ one dietitian whose services would be apportioned among them. It was also suggested that dietitians assume the responsibilities of the laundry and the housekeeping department in the smaller institutions that cannot afford the services of both housekeeper and dietitian.

Hospital meals from the administrator's point of view was presented by Dr. S. S. Goldwater, city commissioner of hospitals. Doctor Goldwater also traced the progress of dietetic service as it has developed through a period of years.

To try to adhere strictly to a budget for the dietetic department would be just as harmful as having a budget for blood transfusions, according to John H. Hayes, superintendent of Lenox Hill Hospital. There is but one manner of controlling food costs, he indicated. First, find a good dietitian and have her do all the purchasing. Second, make certain that everything ordered and billed for is received. Third, employ good chefs and have each one responsible for one or two different items on the menu. Fourth, proper equipment in the kitchen means real economy.

Among the other speakers were Nelda Ross, dietitian, Presbyterian Hospital, Henderika J. Rynbergen, instructor in nutrition for the nurses' training school, New York Hospital, Adeline Wood, dietitian, Mount Sinai Hospital, and Dorothy DeHart, dietitian of Roosevelt Hospital.

Changes Annual Meeting Dates

The Colorado Hospital Association has announced that the date of its annual meeting has been changed from the usual fall meeting to a spring one, to follow the Western Hospital Association meeting. The next meeting, which is scheduled for April 28 and 29, in Denver, will be held in conjunction with the Colorado State Nurses Association. It is the first time these organizations have met together.

March Meeting for Texas Group

The Texas State Hospital Association is holding its annual meeting in Dallas on March 6 and 7 in conjunction with the regional meeting of the American College of Surgeons which is convening in the same city March 4 to 6. The Texas association has invited the Oklahoma Hospital Association, the Louisiana Hospital Association and the Arkansas State Hospital Association to attend its meetings. Robert Jolly, Houston, is in charge of the program.

Record Librarians Elect Officers of State Groups

Four state associations of record librarians elected officers recently, those of Indiana, Georgia, Wisconsin and Massachusetts.

Grace Bartle, St. Vincent's Hospital, Indianapolis, was elected president of the Indiana association and Mary O'Connor, Robert W. Long State Hospital (Indiana University Hospitals), Indianapolis, was elected secretary-treasurer.

The Georgia association elected Wilna Walton, Piedmont Hospital, Atlanta, president and Frances Rutland, McCall Hospital, Rome, secretary-treasurer. Wisconsin record librarians elected Sister M. Syra, St. Francis Hospital, La Crosse, president and Sister M. Claudia, secretary-treasurer of their group.

Elected for two-year terms, the new officers of the Massachusetts association are Eleanor Jones, Newton Hospital, Newton Lower Falls, president and Mrs. Mabel J. Young, Boston Floating Hospital, Boston, secretary-treasurer.

New York Librarians Meet

The first semi-annual meeting of the New York State Association of Medical Record Librarians was held in Albany recently. A luncheon followed the business session in the morning, and the afternoon was given over to the speakers who included Dr. Augustus Wadsworth, director of the division of laboratories of the state department of health, and Frank O. Longcor of the claim department of the Prudential Life Insurance Company. The latter discussed the purposes for which medical records are sought by insurance companies, and offered for approval a form for routine inquiries. The next meeting of the association will be held in Buffalo, May 21 and 22, in joint session with the New York State Hospital Association.

New York Hospital Offers Nutrition Field Course

A field practice course offering observation in all units of the nutrition department of the New York Hospital, New York City, to graduate students, has been announced by Teachers College, Columbia University.

The hospital operates two pay cafeterias, a soda fountain and lunch counter and a visitors' dining room on a commercial basis. General and therapeutic diets for patients are under the direction of dietitians on the patients' floors. The nutrition clinic instructs an average of 900 patients a month.

Students who enroll in the course will be given administrative experience in the preparation and service of about 6,000 meals daily. Lectures and clinics will be conducted by physicians on the staff of the New York Hospital and of Cornell Medical School and by members of the staff of the nutrition department. Students will be permitted to specialize in certain branches of the work if they wish.

Conference Elects Officers

The San Francisco Hospital Conference at its annual meeting elected Frank Schmidt, superintendent, Franklin Hospital, San Francisco, president of the organization and reappointed Thomas F. Clark to the secretaryship.

Hospital Unit Goes to Ethiopia

A fifty-bed hospital unit left New York City January 7, on the *S.S. Steel Age*, bound for Ethiopia. Two physicians sailed with the unit. According to the United Committee for Ethiopia, this organization is approved by the Ethiopian government, and will be sending other hospital units shortly.

A NEW DIAPER . . . MADE OF AN ENTIRELY DIFFERENT SURGICAL-WEAVE FABRIC

This new Curity diaper (not a disposable diaper) was developed after long research and experiment by the leading manufacturer of surgical dressings. It represents the first notable improvement in diaper construction in many years, and was scientifically designed to meet the medical profession's present-day enlightened ideas of a diaper's functions and purpose.

It is made of an entirely new type of material created specifically for this one use—a light, airy, open-weave fabric which has all the desirable characteristics of a surgical dressing. It allows free, soothing circulation of air on baby's skin. Made of two layers of fabric woven together with one smooth selvage, it has no hems to make ridges in tender skin. Yet while this fabric is lighter in weight and much less bulky, it is actually 30% more absorbent than any of the traditional diaper materials.

From a purely practical standpoint these new Curity diapers wash more easily; dry faster in the tumbler, drying room, or out-of-doors, and compare favorably with any other material in wearing qualities. And while unquestionably a great improvement, they are competitive in price with other diapers. A sample will tell you more than we can say. Write for one.

Curity
Nainsook
DIAPERS

LEWIS MANUFACTURING CO.
Division of THE KENDALL COMPANY, Walpole, Mass.
In Canada:
Kendall Mills, Limited, Postal Station K, Toronto

NEW BUILDING PROJECTS

TALLADEGA, ALA. — A brick veneer structure, Virginia colonial in design, is under construction for the County Hospital for the Aged and Infirm. It will contain fifty-two rooms, twenty-four to be bedrooms.

FORT SMITH, ARK. — A nurses' and Sisters' home is under construction at St. Edward's Mercy Hospital at an estimated cost of $150,000. An auditorium with a seating capacity of 300 to be used as a nursing students' classroom and a doctors' clinic has been included in the plans. At present some of the Sisters and nurses are living in the hospital proper, and the completion of the home will consequently add to the hospital's capacity.

SOUTHINGTON, CONN. — The erection of a small hospital building, at an estimated cost of $100,000 not to include equipment, will be begun early this spring. The three-story building has been planned for a normal capacity of twenty-four with a possible emergency increase to thirty-seven. In accordance with the wishes of the late Julia A. Bradley, donor of the funds, the hospital will be known as the Julia A. Bradley Memorial Hospital.

CHICAGO, ILL. — A three-story addition to the surgical institute for crippled children at the University of Illinois College of Medicine is going under construction soon at a cost of about $150,000. It will provide forty additional beds.

HAWARDEN, IOWA. — Voters have approved the proposal to issue $20,000 in bonds for the construction of a municipal hospital.

KANSAS CITY, KAN. — An anonymous gift of $60,000 together with $50,000 from the PWA has made possible the construction of a new children's building at Bell Memorial Hospital which is operated as a part of the University of Kansas medical school.

LOUISVILLE, KY. — A new children's building is about to be constructed at the State Tuberculosis Sanatorium, almost doubling the capacity of the institution, at a cost of $132,000. D. X. Murphy and Brother, architects, designed the three-story fireproof building which will house a complete x-ray department, an operating room for minor surgery and a light therapy department. This is the only state-maintained tuberculosis hospital in Kentucky.

FARIBAULT, MINN. — A new hospital is about to be constructed for the School for Feeble-Minded at a cost of $472,000. It will be a four-story brick structure with a bed capacity of 230. The old hospital will be remodeled and used for housing purposes.

TUPELO, MISS.—Plans are now being drawn for a general community hospital to be erected through the aid of the Commonwealth Fund. The local quota of $40,000 has been raised.

BROOKLYN, N. Y. — A PWA grant of $33,955 has been made to permit repairs on Coney Island Hospital and an additional $41,000 is being asked from the PWA revolving fund in order to complete the work. Forty-five thousand dollars are needed for the construction of an addition to the present building and reconstruction costs of garages and storehouses are estimated at more than $25,000. . . . Plans have been drafted for the construction of a children's wing at the Israel Zion Hospital, according to an announcement made recently by Boris Fingerhood, superintendent.

SYRACUSE, N. Y. — The erection of a new building by federal funds for the University of Syracuse School of Medicine was begun on December 15. This will be another unit in the medical center which now contains the City Hospital, Syracuse Memorial Hospital and the Syracuse Psychopathic Hospital, and will cost $1,250,909.

GOLDSBORO, N. C. — Hospital labor tore down the old frame building previously used for tuberculous patients when it was decided to erect one of the three new buildings under construction at the State Hospital on that site.

SAN HAVEN, N. D. — Adequate facilities for the state care of the tuberculous will be provided through a $300 000 infirmary building at the North Dakota State Tuberculosis Sanatorium, which when complete, will provide 151 additional beds. The six-story building, designed by William Kurke, Fargo architect, will be 175 feet long, with a steel framework and brick exterior. Five floors will be for patients and one for administration. The roof will have a solarium accommodating eighteen beds.

GALVESTON, TEX. — The new $200 000 hospital for crippled children will be a three-story building and will accommodate seventy-five patients. According to the plans, the first floor will include an admitting unit, a swimming pool, a gymnasium and physiotherapy department and a shop for making braces. The second floor is to contain the wards and private rooms, the third, the pediatric and surgical departments.

Builds Addition for Poliomyelitis Victims

Improved treatment for victims of poliomyelitis will be possible in Atlantic County, N. J., when the $34,989 addition to the McSweeney building at the Betty Bacharach Home for Afflicted Children, Longport, is completed.

The addition, designed by Vivian B. Scott, local architect, will have a large physiotherapy pool of concrete lined with ceramic tile. Sea water will be used for what is thought to be the first time in the treatment of infantile paralysis cases. The water will be filtered, purified and heated to 90 degrees. Steel tables are to be placed in the pool so that patients may be treated in six inches of water.

The McSweeney building, which has accommodations for thirty patients will have its capacity increased to sixty-five by the addition. It is the only hospital for the treatment of such cases in the county and as provisions throughout the state for this type of care are inadequate, patients are received from many other counties.

Harlem Hospital Opens New Women's Pavilion

The addition to Harlem Hospital, New York City, was officially opened during January at ceremonies conducted by Dr. S. S. Goldwater, commissioner of hospitals. The addition, a women's pavilion, begun several years ago and not completed because of lack of funds, now increases the bed capacity of the hospital from 325 to 607 and adds 114 bassinets making a total of 721.

In his dedicatory address, Mayor La Guardia spoke of the economic aspects of hospitalization. "Today," he said, "the average family in this city is unable to pay for hospital care. That throws a tremendous burden upon the city which must make some attempt to care for the health of its residents. Public health is the first duty of government. Given a continuance of present economic conditions the cost of hospitals to the city is going to increase materially in the next few years. City hospitals are already overcrowded and overloaded."

The new pavilion will serve women only. It will handle medical, obstetrical and surgical cases and is equipped with a clinic and a dispensary.

To Open Unit for Poliomyelitis

The new addition to the Childrens' Hospital, Denver, Colo., is scheduled for a formal opening on February 17. This unit contains three special pools for the treatment of poliomyelitis and was made possible through a gift from Mrs. H. H. Tammen.

Tri-State Assembly Announces Its Plans for Meeting in Chicago in May

Three general themes will feature the morning sessions of the Tri-State Hospital Assembly, meeting in Chicago on May 6, 7 and 8, according to plans of the program committee under the chairmanship of Dr. Malcolm T. MacEachern.

"The Adequacy of the Care of the Patient" will be the theme for the Wednesday morning session and will be presented from the viewpoint of administrators, medical staff, nurses, pathologists, physical therapists, radiologists, dietitians, and social workers.

On Thursday morning attention will be given to "The Adequacy of Hospital Financing" which will be discussed from the standpoint of current revenues, governmental subsidies, endowments, gifts and donations, group hospitalization and certain special types of financial plans.

The adequacy of special services will be presented on Friday morning with special consideration of the admitting office, the medical record department, anesthesia department, oxygen therapy service, ambulance service, emergency care and operating room and obstetric supervision.

In addition to the hospital associations of Illinois, Indiana and Wisconsin there will be meetings of various other groups from these three states including nurses, dietitians, social workers, record librarians, occupational therapists, physical therapists, hospital accountants, clinical laboratory technicians, chiefs of medical staffs, anesthetists, officers of women's auxiliaries, housekeepers, pharmacists, out-patient department heads and engineers. There will be a special session for trustees on Wednesday evening, May 6.

The related organizations are arranging their own programs for afternoon and, in some cases, for evening meetings. All meetings will be at the Hotel Sherman. An extensive exhibit is being planned.

Coming Meetings

Congress on Medical Education, Medical Licensure and Hospitals.
Next meeting, Chicago, Feb. 17-18.

New England Hospital Association.
Next meeting, Boston, Feb. 27-29.

Texas Hospital Association.
Next meeting, Dallas, Mar. 6-7.

Ohio Hospital Association.
Next meeting, Columbus, Apr. 14-15.

Virginia Hospital Association.
Next meeting, Old Point, Apr. 16-17.

Association of Western Hospitals.
Next meeting, San Francisco, Apr. 20-23.

Alabama Hospital Association.
Next meeting, Montgomery, Apr. 21.

Pennsylvania Hospital Association.
Next meeting, Pittsburgh, Apr. 22-24.

Iowa Hospital Association.
Next meeting, Apr. 27-28.

Colorado Hospital Association.
Next meeting, Denver, Apr. 28-29.

Mississippi Hospital Association.
Next meeting, Greenville, May 4.

Tri-State Hospital Assembly. (Indiana, Illinois, Wisconsin)
Next meeting, Chicago, May 6-8.

American Medical Association.
Next meeting, Kansas City, Mo., May 11-15.

Minnesota Hospital Association.
Next meeting, St. Paul, May 21-22.

Hospital Association of New York State.
Next meeting, Buffalo, May 21-22.

New Jersey Hospital Association.
Next meeting, Atlantic City, June 4-6.

Catholic Hospital Association.
Next meeting, Baltimore, June 15-19.

Three National Nursing Organizations, Biennial Meeting.
Next meeting, Los Angeles, June 22-27.

Manitoba Hospital Association.
Next meeting, Winnipeg, June 25-26.

American Dietetic Association.
Next meeting, Boston, Oct. 11-16.

Kansas Hospital Association.
Next meeting, McPherson, Oct. 31.

Oppose Solicitation of Funds

The National Medical Association and the National Hospital Association, organizations of Negroes engaged in health work, have recently made public the text of resolutions adopted by the two associations concerning the Negro National Hospital Fund and its organizer, Rev. Amos H. Carnegie.

The gist of the long set of resolutions is that the two organizations "go on record as being opposed to the solicitation and collection of funds from the public by Rev. Amos Carnegie" for the purpose of building additional hospitals for Negroes. The resolutions point out that several needed Negro hospitals have been forced to close for lack of funds.

College Course in Nursing Announced by St. Vincent's

St. Vincent's Hospital, New York City, together with the College of the Mount St. Vincent, is opening a four-year college course in nursing for 1936-37. Candidates for admission must be sixteen years old and have the equivalent of a high school diploma. The course of study is four years with a month's vacation every summer, and leads to a bachelor of science in nursing degree.

The first year is spent at the college, in science and liberal arts work, the second and third years emphasize the principles and practice of nursing and medical science with cultural courses in allied fields, the fourth year, the student finishes her professional training at the hospital and at the college.

Graduate nurses who have high school diplomas will be admitted to the college on advanced standing, according to their ratings in the nursing school.

Celebrates Tenth Anniversary

The tenth anniversary of the University of Rochester school of medicine and dentistry, the Strong Memorial Hospital and the school of nursing was celebrated with a two-day program during the middle of January. Twenty speakers discussed the research problems carried on by the school and hospital during the past decade, and special exhibits were on display in the laboratories. Ward rounds were made by medical visitors in the various clinical departments. A small book was published tracing the history of the hospital from the time of the $10,000,000 gift by the General Education Board and George Eastman and the additional $1,000,000 gift for building purposes.

Hospital Suffers Fire Loss

A fire on the eighth floor of the Baptist Hospital, New Orleans, caused damage estimated at $2,000, but did not endanger any patients. The fire was caused by a series of explosions from anesthesia gas.

A. M. A. Hospital Session Selects Varied Problems

The thirty-second annual congress of the Council of Medical Education and Hospitals of the American Medical Association, meeting with the Federation of State Medical Boards of the United States, will be held in Chicago on February 17 and 18.

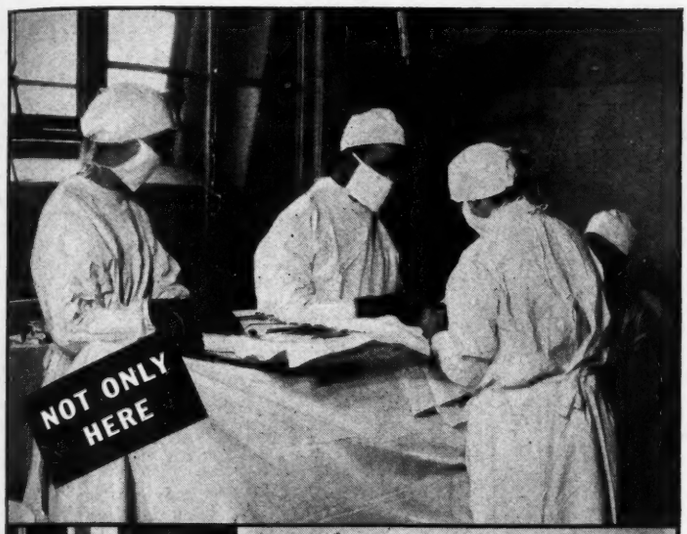
The session devoted to hospitals is scheduled for Tuesday afternoon when Dr. J. A. Curran, executive secretary of the New York Committee on the Study of Hospital Internships and Residencies will talk on the "Function of the Hospital in the Training of Interns and Residents."

"The Laboratory of Pathology in the Small Hospital" is the subject of the talk to be given by Howard T. Karsner, director of the institute of pathology, Western Reserve University and the University Hospitals, Cleveland. The use of the out-patient department in medical education will be discussed by Dr. W. McKim Marriott, dean of the Washington University School of Medicine, St. Louis, who will present new viewpoints.

The report of the Council on Medical Education and Hospitals will be given by Dr. Ray Lyman Wilbur, chairman, at the opening session on Monday morning.

HOW TO CUT YOUR COST OF GENERAL DISINFECTION

and get more dependable germicidal action



"LYSOL" IS MOST EFFICIENT AND ECONOMICAL

Photograph taken at the Park East Hospital, New York City, especially for "Lysol"

"Lysol's" concentrated power makes truly germicidal cleaning solutions at lower cost than "cheap" disinfectants

ORDINARY cresol compounds may *seem* cheaper than "Lysol" for general disinfection. But actually the cost per gallon of *effective germicidal* solution is considerably higher. For, to get germicidal effectiveness equal to that of the proper "Lysol" solution, you would have to use 2 or 3 times the *quantity* of these so-called cheap disinfectants. Frequently this is not done—with the result that such solutions often have *little real disinfecting value.*

"Lysol"—with its high phenol coefficient of 5—is already standard in leading hospitals for operating room use; it is considered essential in sterilization of rubber equipment, gloves, instruments, etc.—because "Lysol" is a uniform, *branded* disinfectant which provides positive germicidal action without danger of harm to such equipment.

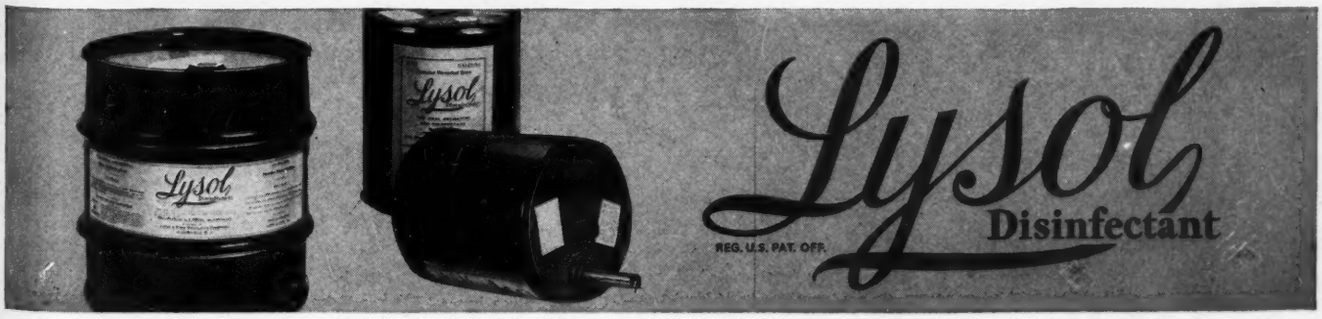
Many hospitals, however, using "Lysol" regularly for their most exacting requirements, fail to realize the great economy also of standardizing on this dependable product for *all* disinfection.

"Lysol" is a non-specific germicide; does not lose its potency in the presence of organic matter—when many other disinfectants lose their effectiveness either wholly or in part. "Lysol" is safe—contains no free alkali to harm tissue, fabric, or steel.

Yet with all these vitally important superiorities to ordinary disinfectants, the concentration of "Lysol" is such that it is actually *cheaper* in general disinfection—and eliminates the need of having two or more kinds of disinfectants on hand.

AS LOW AS $1.25 PER GALLON...

on 50-gallon contracts, delivered 10 gallons at a time as required. For complete details, address your supply house or Lehn & Fink, Inc., Hospital Dept. MH-2, Bloomfield, N. J.



U. S. and Canada Now Have Official Journals

Both the American and the Canadian hospital associations are now engaged in hospital journalism. The first issue of *Hospitals*, the new official journal of the American Hospital Association, appeared on January 1 under the editorship of Dr. Bert W. Caldwell, executive secretary of the association. It is a standard size magazine, 8½ by 11½ inches, with an attractive cover which carries in colors the well known seal of the association. It contains in the first issue a total of 136 pages. Special departments include: editorials, "Among the Associations," "Of Special Interest to the Buyer" and "The Hospital Book Shelf."

The Canadian Hospital Council has recently announced the appointment of Leonard Shaw, superintendent, City Hospital, Saskatoon, Sask., as editor of the *Canadian Hospital*. This is under an arrangement whereby the *Canadian Hospital* becomes the official journal of the Canadian Hospital Council but continues for the present to be owned by the Edwards Publishing Company, Toronto. The *Canadian Hospital* is a journal of approximately sixty pages and is just commencing its thirteenth year.

Nonindigent Patients Pay

Of the first 300 patients at the new Queens General Hospital, New York City, 4½ per cent were able to pay their way. Emergencies, accidents and liabilities brought the proportion of nonindigent patients to about 8 per cent. The city charter provides that patients able to pay, must do so in a city hospital. The dispensary of the new hospital had about 1,000 applicants for treatment during November. Of this total 11½ per cent were rejected as ineligible, mostly because they were found able to pay for treatment.

Victory Hospital Asks Processing Tax Refund

The board of directors of the Victory Memorial Hospital, Waukegan, Ill., recently adopted a resolution calling upon all firms that have sold goods to the hospital upon which processing taxes have been levied to refund such taxes to the hospital. The board also declares in its resolution, "That if, when and as other federal acts, kindred to NRA and AAA, such as the Guffey coal act, the Wagner acts which affect wages and inherently caused price increases on production within a state, and the Bankhead cotton act are declared unconstitutional, a like demand be made for a return of all amounts of money unlawfully taken from the hospital association by reason of such acts, if declared unconstitutional."

The board, furthermore, petitioned the President and Congress to refrain from providing taxes or bounties and gifts to producers within states "in order to attempt to do indirectly what the U. S. Supreme Court says cannot be done directly by processing taxes."

Evening Clinic Opened

An evening clinic, recently opened by the New York Dispensary, New York City, is for the benefit of workers with family obligations whose salaries are less than thirty-five dollars a week and for students with little money. A complete series of medical and dental service is given by specialists from the city's leading hospitals, and doctors' and nurses' salaries are paid by the dispensary. Patients pay fifty cents a visit and low rates are made for such services as x-ray, hospital care and dental reconstruction. The clinic had originally intended to limit its scope to workers on home relief and WPA staffs.

Reorganizes Sanitarium for Memorial to His Wife

All the stock of the Oconomowoc Health Resort, a sanitarium for nervous and mental disease, Oconomowoc, Wis., has been purchased by Dr. Arthur W. Rogers, director and owner of the controlling interest for many years, who is converting it into a nonstock, nonprofit making institution as a memorial to Mrs. Rogers.

It will be known as the Rogers Memorial Sanitarium, operated by Doctor Rogers under the direction of a board of trustees. In addition he has arranged that his entire estate will be left as an endowment for the institution, the income to be used to establish a psychiatric laboratory, to hold clinics and graduate courses in psychiatry and neurology and to publish various papers.

The sanitarium, which will be conducted at minimum cost to its patients, is made up of a main building and a group of cottages on a fifty-acre estate. It is estimated that Doctor Rogers' gift is worth about $1,000,000. Dr. James C. Hassall will continue as superintendent.

Association of Collegiate Schools of Nursing Name Organizations Accepted

The Association of Collegiate Schools of Nursing has announced the schools admitted to active and associate membership in its organization. The apparent duplication of some schools as both associate and active members is due to the fact that collegiate schools offer two types of programs, the undergraduate, or basic level, and the advanced, designed to meet the needs of graduate nurses.

Those institutions which operate schools on both levels and qualify for active membership in the association on one type and not on the other are listed both as active and associate. It is expected that as the organization develops, the types of membership will be modified, but at present the membership schools come in under four groups.

Accepted for active membership on the basis of their combined academic and basic professional programs are Skidmore College School of Nursing, Saratoga, N. Y., and the Yale University School of Nursing, New Haven, Conn.

On the basis of their combined academic and advanced professional programs, Catholic University, Department of Nursing Education, Washington, D. C.; George Peabody College for Teachers, Department of Nursing Education, Nashville, Tenn.; St. Louis University School of Nursing, St. Louis, Mo.; Syracuse University, Department of Public Health Nursing, Syracuse, N. Y.; Teachers College, Columbia University, Department of Nursing Education, New York City; University of Oregon, Department of Nursing Education, Portland; University of Virginia, School of Nursing Education, Charlottesville, and Washington University School of Nursing, St. Louis, Mo., were accepted for active membership.

For both their basic and advanced professional programs, combined with academic, the association admitted to active membership Simmons College School of Nursing, Boston; University of California School of Nursing, Berkeley; University of Washington School of Nursing, Seattle; Vanderbilt University School of Nursing, Nashville, Tenn., and Western Reserve University School of Nursing, Cleveland.

Associate members, accepted on the basis of their combined academic and basic professional programs, are Duke University School of Nursing, Durham, N. C.; Rochester University School of Nursing, Rochester, N. Y.; St. Louis University School of Nursing, St. Louis; University of Michigan School of Nursing, Ann Arbor; University of Oregon School of Nursing, Portland, and Washington University School of Nursing, St. Louis.

NAMES IN THE NEWS • • •

DR. JAMES S. HAMMERS, former superintendent of the Pittsburgh City Home and Hospital, Mayview, Pa., has been appointed medical director of the Lancaster County Hospital for Insane, Lancaster, Pa.

DR. WILEY EGAN WOODBURY, former director of Fifth Avenue Hospital, New York City, died in St. Joseph's Hospital, Phoenix, Ariz., following a brief illness. Doctor Woodbury resigned from his post at Fifth Avenue Hospital when that institution merged last fall with Flower Hospital. He was at one time assistant superintendent of Grace Hospital, Detroit, later becoming superintendent of Ionia State Hospital, Ionia, Mich. In 1911 he became superintendent of the Philippine General Hospital in Manila and in 1914 resigned to become director of the Hahnemann Hospital, Philadelphia. After several years of war service, he became affiliated with the Fifth Avenue Hospital.

E. KATHLEEN RUSSELL, professor of nursing education at the University of Toronto, has been given a three months' leave of absence by that institution in order to permit her to accept an invitation from the Florence Nightingale International Foundation to confer with them in plans for the promotion of facilities for advanced nursing education at the University of London.

BERL HOOVER is succeeding MARTHA C. OOSTEN as superintendent of Jasper County Hospital, Rensselaer, Ind. Miss Oosten retired on January 1 in order to be married.

DR. NATHAN PORTER COLWELL died at his home at the age of sixty-five as the result of a cerebral hemorrhage. Doctor Colwell had been secretary of the council on medical education of the American Medical Association from 1906 until 1931, and was managing editor of the *Federation Bulletin* of the Federation of State Medical Boards of the United States.

CAROL MARTIN, R.N., director of state nursing education in the Nebraska state department of public health has been appointed head of the newly created bureau of education and registration for nurses.

FERN COX is the new superintendent at the Marshall County Hospital, Plymouth, Ind., where she succeeds ROSE MOST.

SISTER FRANCES DE CHANTAL has been named superintendent of Good Samaritan Hospital, Dayton, Ohio.

M. MAE LANKFORD, R.N., superintendent of nurses at Johnston-Willis Hospital, Richmond, Va., has been made superintendent of the institution to succeed M. HASKINS COLEMAN, JR.

MAUDE J. KEAN, superintendent of nurses at Coney Island Hospital, Brooklyn, retired recently after having been in the executive nursing service with the New York City hospital system for thirty-two years.

ROWENA H. RAYMOND for the past eleven years superintendent of the Lawrence Hospital, Bronxville, N. Y., has resigned from that institution.

MARGARET L. PEARSON, of the Central Maine General Hospital, Lewiston, Me., has been put in charge of the department of physiotherapy and x-ray at the Maine General Hospital, Portland, Me. Before Miss Pearson specialized in this field, she was assistant superintendent at the Augusta General Hospital, Augusta, Me.

DR. JAMES NEWBEGIN WORCESTER, former director of Beekman Street Hospital, New York City, died at the age of fifty years in that city. Doctor Worcester was responsible for the reorganization of the institution in 1923. In recent years he had withdrawn from active service.

ADA C. ZORGER, assistant superintendent of the Lock Haven Hospital, Lock Haven, Pa., and acting superintendent since the resignation of ELEANOR R. FAUNCE, has been made superintendent of the institution.

FRANK KIERNAN, executive of the Massachusetts Tuberculosis League, has been appointed director of the New York Tuberculosis and Health Association.

MRS. R. G. CANADA is the new superintendent of the Good Samaritan Hospital, Galion, Ohio.

GERTRUDE HAYNES succeeded MAMIE JO HENRY as superintendent at Hernando General Hospital, Brooksville, Fla.

ETHEL L. BROWN, matron at Onoway Municipal Hospital, Onoway, Alberta, has been appointed superintendent of the Hanna Municipal Hospital, Hanna, Alberta.

K. ETHEL GRAY, suffering from ill health as the result of injuries sustained in an automobile accident, resigned from the superintendency of the Kootenay Lakes General Hospital, Nelson, B. C., and VERA EIDT, acting superintendent, is taking her place.

Hospitals in Cook County Show Free Care Decrease

The total hospital days' care in Cook County, Illinois, for October, 1935, as compared with October, 1934, showed an increase of .5 per cent, according to statistics compiled by the Council of Social Agencies, while the days' care to free patients declined 1.4 per cent.

One general and three special government hospitals reported a decrease of .2 per cent for both total and free care while twenty-two nongovernment general and nine nongovernment special hospitals showed an increase of 1.4 per cent in total days' care and a decline of 5.2 per cent in days' care to free patients.

Total clinic visits increased .4 per cent and free visits 1.5 per cent in October, 1935.

Federal Ruling Is Guide on Filing Income Tax

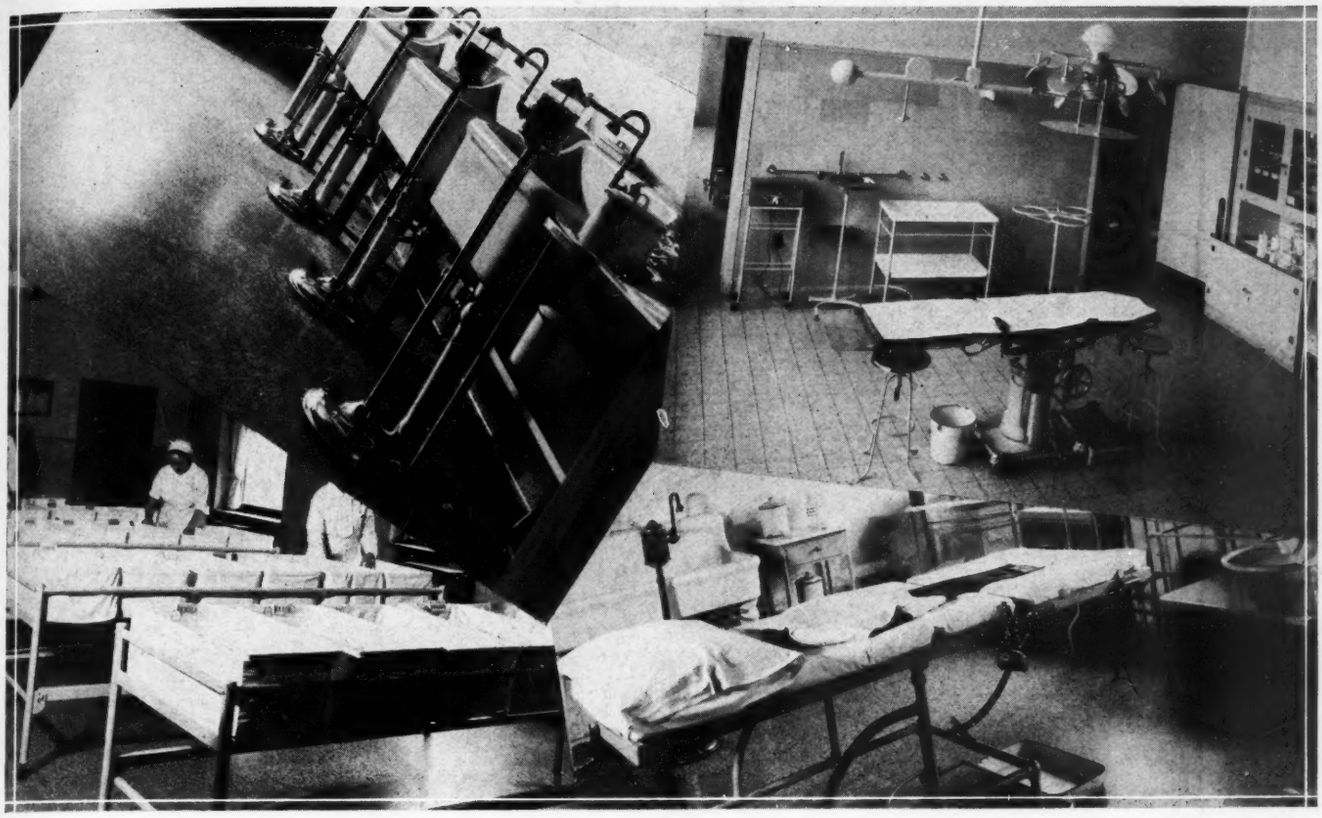
Hospital employees who receive room, board or other services as part of their salary must include the fair market value of the thing taken in payment in computing their income for purposes of paying income taxes to the federal government, according to a ruling from the Commissioner of Internal Revenue, provided the employee has some choice in the matter. If the employee has no choice and merely accepts living quarters for the convenience of the employer, the value of such quarters need not be included.

Article 53 of the treasury department's regulation 77 covers this matter. It provides:

"Where services are paid for with something other than money, the fair market value of the thing taken in payment is the amount to be included as income. If the services were rendered at a stipulated price, in the absence of evidence to the contrary, such price will be presumed to be the fair value of the compensation received. . . . When living quarters such as camps are furnished to employees for the convenience of the employer, the ratable value need not be added to the cash compensation of the employees, but where a person receives as compensation for services rendered a salary and in addition thereto living quarters, the value to such person of the quarters furnished constitutes income subject to tax. . . ."

Surgeon General Retires

Dr. Hugh S. Cumming, surgeon general of the U. S. Public Service, has submitted his resignation to the President, effective February 1. It is reported that Dr. Thomas Parran, Jr., will be his successor.



Where you need Competency

In every department of the Hospital 100 per cent Sanitary conditions are imperative for the welfare of patients, and growth of the Hospital.

ANTISEPTIC BABY OIL

MIDLAND ANTISEPTIC BABY OIL is pure, healing and soothing—not sticky or greasy and is a protection against rashes, infections and other infant skin troubles. It is also recommended for adult skin care.

MIDLAND GERMOLYPTUS a Hospital disinfectant and Germicide is nonpoisonous, stainless, and has a pleasant odor.

GERMOLYPTUS

Germicide and Disinfectant

THIRTY THREE YEARS SERVING THE NATIONS' HOSPITALS

Write Department M.H.-2

1903 MIDLAND CHEMICAL LAB., INC. 1936

at DUBUQUE, IOWA, U.S.A.

READER OPINION • • • •

Polygon Hospitals

Sirs:

I am enclosing a general design of a typical floor plan suitable either for a general or psychopathic hospital, the sketch enclosed being for the latter. (See cut.)

The principal thought in the design was decreased initial cost and a considerable decrease in cost of operation in comparison with existing plans. . . . A few of the reduced cost features . . . are:

Less than one-half of facing materials are needed to present a suitable appearance. Distance traveled to various wards varies from one-eighth to one-fourth of usual designs. Centralized control and corresponding ease of administration. Greatly reduced steam heating lines resulting in 25 per cent fuel saving for both heating and hot water supply. A 15 per cent saving in electric lighting and power costs. A saving in horizontal piping and sewers of 75 to 87½ per cent. . . .

The entire scheme was devised with but two thoughts in view—minimum first cost and minimum cost of operation without sacrifice of any useful feature. Function in this case was the only desire.

As most hospitals should be designed to grow, this plan lends itself admirably to such a situation, as one or more wings may be constructed and others added at will.

After twenty years of experience in designing structures of various types . . . I . . . arrived at the conclusion that a full circle was efficiency at its maximum. However, since it is considerably more expensive to construct buildings with circular outlines and also since they are not so desirable for occupancy, the many sided polygon proved to be the most desirable. . . . I therefore copyrighted the design of any polygonal building with wings radiating toward the center. I have designed many types of such a building and many variations from the type enclosed may be had. . . . The room arrangement on my sketch is tentative and subject to changes. . . . The design I am sending occupies considerable space, preferably not less than 300 feet square, but it is also true that the proper location for a hospital should provide sufficient space to be free from street and other acoustical disturbances. . . .

MAURICE JAYNE,
Architect.

Oklahoma City, Okla.

It is not entirely clear from Mr. Jayne's letter and plan whether the building is intended to be single-storied or multiple-storied. No provision is indicated for either elevators or entrances. Comments from readers of The MODERN HOSPITAL will be welcome.—Ed.

"So Here Goes"

Sirs:

The new cover page arrived this morning. I will give you my impressions. . . . Not being an artist, I cannot sit down and manufacture an artistic creation, but after it is manufactured I can tell whether I like it. . . . So here goes.

In the first place, I question a little whether the large space of white in the upper portion of the page isn't a little too much. I am not sure of this. I would hardly know how to correct it but how would a little border of the color of the rest of the page, a narrow one not over one-eighth of an inch, running around the sides and top do? A little suggestion; perhaps I am wrong.

As to the rest of the criticism, I call your attention to the fact that your page is divided into two parts, an upper and a lower. In the upper portion the motif is a circle. In the lower portion the motif, at least of the colored part, is rectangular. Now under these circumstances my own feeling is that the lettering you have chosen does not belong—it is neither one thing nor the other. I particularly dislike the word "the" in script, . . . I don't know how to correct this but my suggestion would be to develop a special type for this title. . . .

The general effect, though, is very good and I like it much better than the old page cover. To be sure, you have chosen an exceptionally good inset for this sample, but in any case I think it is an improvement. My suggestions may be perfectly vacuous and of course you are at perfect liberty to throw them in the wastebasket. . . .

WILLIAM A. WHITE, M.D.,
Superintendent.

St. Elizabeth's Hospital,
Washington, D. C.

Sirs:

. . . . I like the new design very much and approve of the color but, at the moment, like it no better than the old color. . . .

LULU G. GRAVES.

New York City.

Sirs:

I must confess that I was rather skeptical of the idea of changing the cover, but the new one is quite attractive. . . .

Three cheers and a tiger for Glenn Frank's article, "The Sabotage of Self-Reliance." It is the best thing that has appeared in The MODERN HOSPITAL for many a moon and I wish that every hospital trustee could read it. If reprints of it are ordered, please put me down for fifty and send us the bill.

BASIL C. MACLEAN, M.D.,
Director.

Strong Memorial Hospital,
Rochester, N. Y.

Sirs:

From the time the January number came I have kept it around where I could see it. At first the new cover did not appeal to me as much as did the old one. The more I see of it, however, the more I like it. I am not entirely sold on the shade of yellow. It seems to me to border a little on the pink. That, however, may improve with age. . . .

ALBERT W. BUCK,
Superintendent.

New Haven Hospital,
New Haven, Conn.

Sirs:

In designing this new cover, I believe that the efforts of Mr. Teague are worthy of high tribute. . . . Though the new cover meets with my approval, I fear that I shall miss, for a time, the cover on the magazine which I have grown to regard as a friend arriving each month. . . .

CAROLYN E. DAVIS, R.N.,
Superintendent.

Good Samaritan Hospital,
Portland, Ore.

Sirs:

I . . . must frankly say that I feel that it is almost a work of art. It comes, however, as a severe shock to those of us who have got so accustomed to the magazine in its original form.

A. K. HAYWOOD, M.D.,
General Superintendent.

Vancouver General Hospital,
Vancouver, B. C.

Sirs:

Your new cover derives strength from its simplicity. I find it highly pleasing and most effective.

S. S. GOLDWATER, M.D.,
Commissioner.

Department of Hospitals,
New York City.

Sirs:

While I liked the old cover, I think that the time is ripe to give "Modern" Hospital a "modern" cover. It has snap and dignity as well as simplicity.

JOHN R. MANNIX,
Assistant Director.

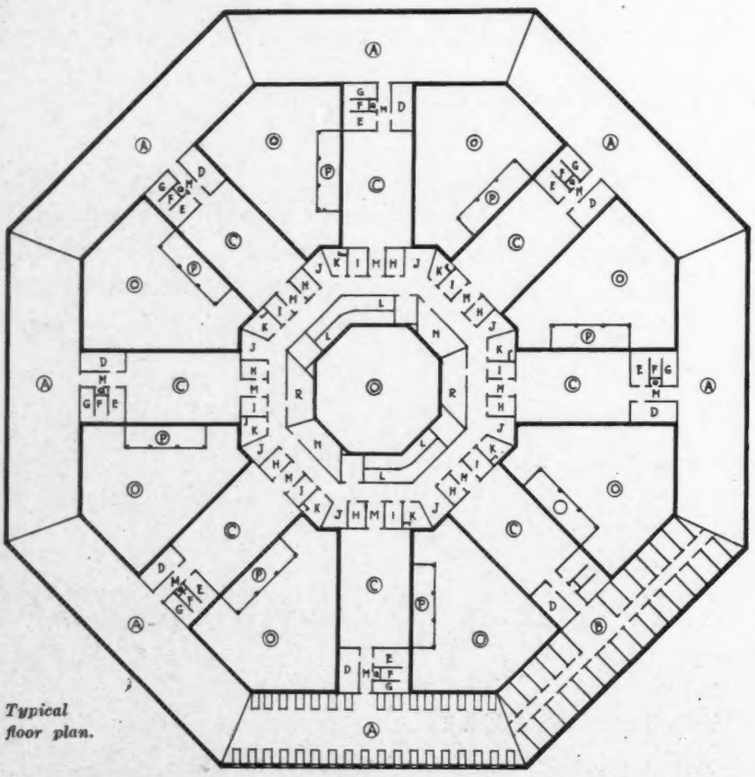
University Hospitals,
Cleveland.

Sirs:

I was always partial to the covers you have used for many years and would not have deemed the style improvable had you not shown me. . . .

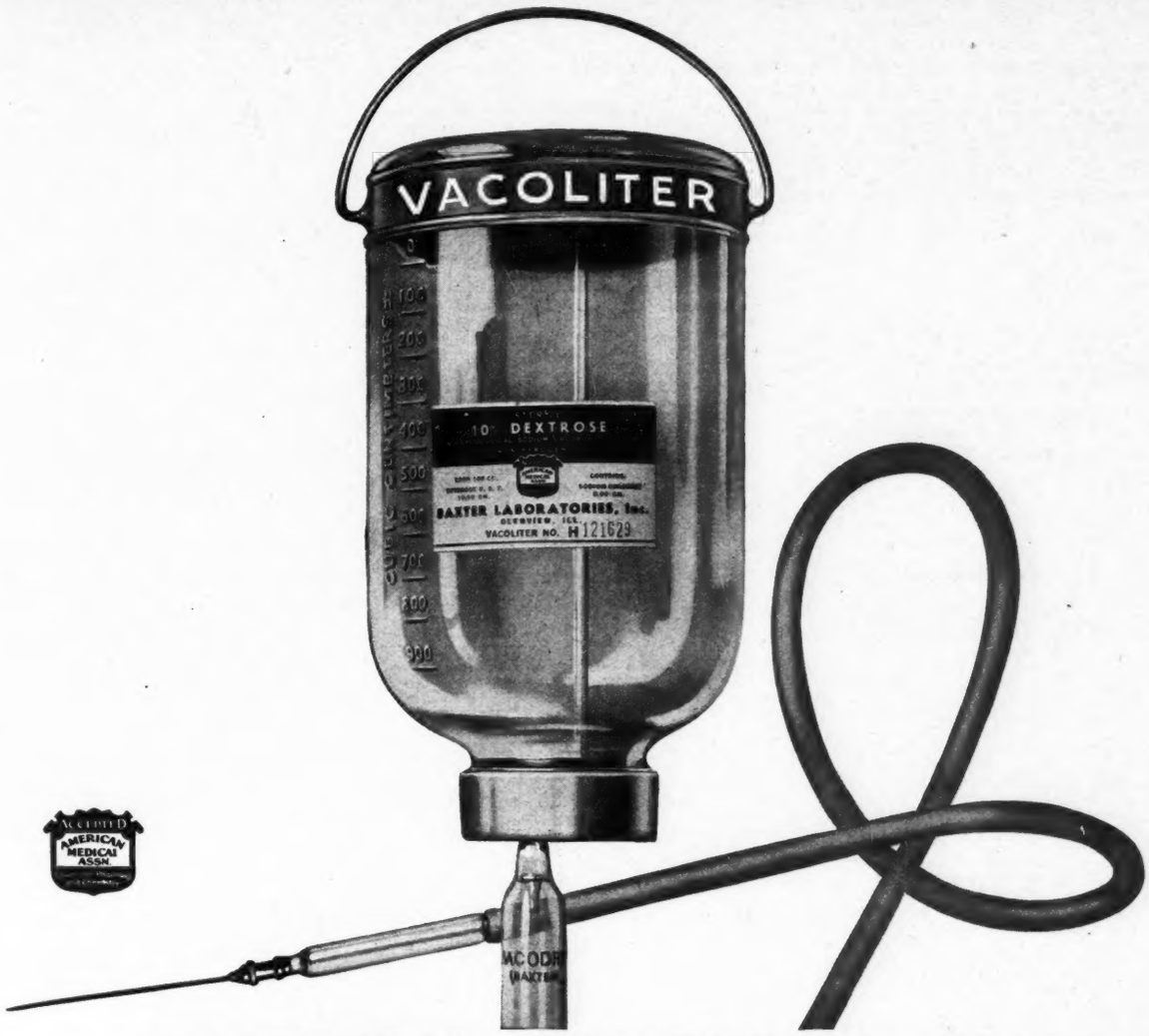
LEE C. GAMMILL,
Superintendent.

Baptist State Hospital,
Little Rock, Ark.

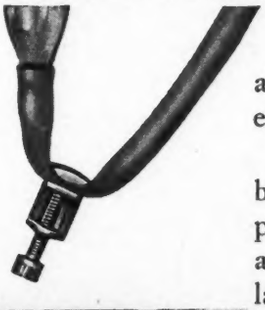


Typical floor plan.

A—33 Bed Wards; B—26 Bed. Wards; C—Day Rooms; D—Patients' Clothing; E—Toilets; F—Dressing Rooms; G—Shower Baths; H—Attendants' Office; I—Nurses' Office; J—Visitors' Alcove; K—Doctors' Office; L—Stairs or Ramps; M—Halls; N—Supplies; O—Open Air Light Courts; P—Screened Open Air Porches; Q—Utility Closets; R—Unassigned Space.



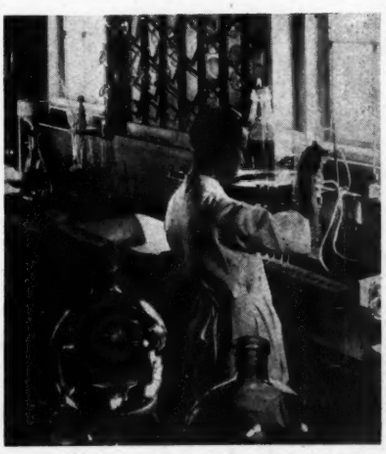
BAXTER'S INHERENT QUALITY NOW MADE IMPREGNABLE!



IT is a part of the Baxter creed that men and companies are capable of consistent progress. Thus, doing a thing well at Baxter Laboratories is but a step toward the ultimate objective of doing that thing *supremely* well.

The Baxter solution you use today is superior to the solution you used twelve months ago. And the solution you use twelve months hence will be finer, because Baxter's goal is a quality *ideal* to be reached even though necessity has been satisfied and complete usefulness achieved.

Baxter experts are imbued with the desire to outdo tomorrow, that in which they take great pride today. This perpetual striving for a quality ideal is your certain assurance that all your solution problems are *safely* entrusted to Baxter.



Baxter quality is made impregnable because Baxter regards each completed task on the path to perfection as but the laid ground work for a larger job to start tomorrow.

BAXTER LABORATORIES, Inc.
GLENDALE, CALIF. • GLENVIEW, ILL.

WHEREVER YOU ARE THERE IS A COMPLETE WAREHOUSE STOCK NEAR YOU

Distributed East of the Rockies by

AMERICAN HOSPITAL SUPPLY CORPORATION

Merchandise Mart CHICAGO **315 Fourth Ave. NEW YORK**

BAXTER'S INTRAVENOUS SOLUTIONS IN VACOLITERS

Sirs:

The old cover has seemed to me for some time to be rather passé but to those of us who have been reading the magazine for a long time I do not believe the cover made much difference. However, the new readers who are not so well acquainted with the contents . . . might put greater emphasis upon its cover design.

FRANK J. WALTER,
Superintendent.

St. Luke's Hospital,
Denver, Colo.

Sirs:

The new cover . . . is stunning, in composition and color. May it typify the simplicity, directness, and vigor of your editorial leadership and of our thought, speech and action.

JOHN R. HOWARD, JR.,
Superintendent.

Muhlenberg Hospital,
Plainfield, N. J.

Sky Pilots

Sirs:

The medical department has not actually adopted and developed an ambulance airplane. There has been some thought and attention toward the possible adaptation of some of the commercial transports for ambulance purposes in time of war. Such a procedure would involve only the removal of passenger seats and the installation of litter supports with some additional equipment, as water tanks, dressing cabinets, oxygen supply apparatus. In addition, some investigation is being conducted relative to the possible selection of a light commercial type airplane for routine ambulance use in the army.

The Army Air Corps has at the present time one airplane ambulance which is actually a converted transport type. This airplane is a single motored high wing monoplane with a cruising speed of approximately 100 miles an hour, capable of transporting two litter patients and an attendant, in addition to the pilot. It is equipped with an emergency drug and dressing cabinet, a case of splints and a water tank. At present it is stationed at one of the Air Corps fields at San Antonio, Tex., and is utilized in serving some of the isolated border stations.

C. R. REYNOLDS,
Surgeon General.

U. S. Army,
Washington, D. C.

Going Beyond One's Authority

Sirs:

I noticed in The MODERN HOSPITAL (December, page 74—Ed.) an important question which I have called to the attention of several pathologists who were unacquainted with it, namely, . . . whether a pathologist who does an autopsy has a legal right to take any organs from the body, even though he has had permission from the nearest of kin to perform the autopsy.

Your article stated that he did not have this legal right and that a special statement should be made in connection with the consent of an autopsy to protect the pathologist. . . . This should be called to the attention of the pathologists of the country and to the hospitals because every day we are taking organs from interesting cases for pathologic conferences which we, apparently, have no legal right to do. . . .

R. B. H. GRADWOHL, M.D.,
Director.

Gradwohl Laboratories,
St. Louis.

More About Clinic Abuse

Sirs:

In a communication from Alexander Ropchan appearing in the January issue of The MODERN HOSPITAL (page 118) captioned "Clinic Abuse," he questions the accuracy of the percentage calculations in a study of selected out-patient departments for the Chicago Medical Society conducted by this office. Mr. Ropchan states: "The 13 per cent referred to is based on a selected group of admissions." In referring to the report's conclusions concerning percentages, the editor added: "This should have been qualified."

Manifestly, the sense of such a comprehensive report as the one under consideration cannot be determined by a reference to any one paragraph. One must read the entire report to accurately appraise the facts presented and their implications. The qualifications aptly suggested by the editor are thickly scattered throughout the voluminous report, beginning with the first page, and copies were made available to all who requested them.

Referring to the use of a "selected group of admissions" upon which to base percentage calculations, I would say that it is precisely because relief cases constituted a bona fide "selected group of cases" that they were not taken into consideration, except as an interesting factor per se. The same holds true of the other cases excluded from the percentage calculations. We felt, and unequivocably stated, that relief cases, hospital employees, students, wards of the state, must be excluded from calculations since they did not represent "regular routine admissions."

Statisticians of repute do not lump together divergent units indiscriminately and unintelligently, and no one else does so unless wishing deliberately to prove some preconceived assumption. A classification of the material at hand should be so made as to be indicative of the truth sought, and it is on such a basis, as is clearly stated repeatedly in the report, that we obtained the number of "those able to pay private physicians"—amounting to 13 per cent.

WILLIAM H. WALSH, M.D.,
Director of Study.

Chicago Medical Society,
Chicago.

No Shortage in Ohio

Sirs:

We have been very much interested in the articles in The MODERN HOSPITAL which have made reference to nursing in Ohio. . . . You will remember I wrote you last year relative to a statement made by Doctor Woods, superintendent, St. Luke's Hospital, Cleveland. After we challenged the statement, your office forwarded this information to Doctor Woods and he in turn wrote us relative to the statement which he had made in good faith and, as is usually the case, stated that the superintendent of nurses had given him this information. I have watched carefully for some reference to be made to our protest through the columns of your excellent magazine but to date have not noted such correction. . . .

We are now writing . . . relative to an article in the December MODERN HOSPITAL entitled "We May Even Run Short of Nurses." We are interested in this article because certain statements have been made relative to Ohio which are not authentic. One is "Ohio—some specialties lacking."

We have on file in our state headquarters office applications of nurses who are well qualified for the various phases of nursing work, therefore it does not seem that anyone should state that nurses have not been available.

Of course you realize that conditions of employment and salaries offered are responsible, in many instances, for the inability of some of our institutions to secure nurses who have specialized for teaching as well as for other important departments of hospitals.

One other statement in this article has to do with the Toledo district. . . . This statement is most absurd. . . . In Toledo there has been great unemployment among nurses.

Toledo Hospital has a capacity of 350 beds. Its daily average of patients in 1934 and 1935 was approximately sixty-nine. Due to lack of clinical material, the student nurses in that institution were used to give nursing care to all patients, regardless of their ability to pay for special duty nurses.

St. Vincent's Hospital, which is one of the largest hospitals in Toledo and has a large school of nursing, had a high daily average of patients, but, for the most part, they were unable to pay for hospital service, and very few special duty nurses were given employment. Lucas County Hospital, being a county institution, does not employ special duty nurses. Flower and Women's Hospitals have, likewise, had a small daily average of patients. . . .

All these (Toledo) institutions have, for the most part, not hesitated to ask the registered nurses of Toledo to give free nursing service. Quite naturally, the nurses are now beginning to refuse to give so much nursing service in exchange for board, room and uniform laundry. . . . They find it necessary to have clothing, etc.

It is interesting to note that salaries of the superintendents in three of the hospitals mentioned . . . are rather large. . . .

There should be no confusion in the minds of either hospital executives or graduate nurses relative to the place of ward maids. Every hospital should employ ward maids to do routine nonprofessional duties but these duties should not include nursing care for patients. . . .

It is of interest . . . to remember that the American Red Cross has demonstrated beyond a doubt that it is possible to secure well-qualified, graduate registered nurses to go into every community and give quality nursing service. . . .

(MRS.) ELIZABETH P. AUGUST, R.N.,
General Secretary.

Ohio State Nurses' Association,
Columbus, Ohio.

"Worldly Appreciated"

Sirs:

The Junta Central de Beneficencia y Asistencia Social de Chile is willing to organize an efficient department of dietetics and nutrition that would take charge of the problems of the hospitals' food requirements.

As we know the great development of these departments in the hospitals of the U. S. A., we would be sincerely thankful to be put in touch with the American Dietetic Association. . . . We are especially interested to obtain data about the organization of dietitians' schools and their programs, and in receiving any reports or publications connected with our problems, naturally paying for them as we are not yet able to send our publications in exchange till next year.

As we constantly read the dietetic section of The MODERN HOSPITAL we are sure that you will do your best to satisfy our wish of knowing the worldly appreciated dietetic and nutrition organizations of the U. S. A. . .

DR. JULIO SANTA MARIA,
Chief, Dietetic Department.

Junta Central de Beneficencia y Asistencia Social,
Santiago de Chile.

Chain Letters for Hospitals

Sirs:

Enclosed is a new one to me—a chain letter method of raising money for hospitals. I have never heard of the Ruby Hospital nor can I find it listed in any of the directories. My secretary copied this from one of our employees who is one of the "chain gang. . . ."

J. DEWEY LUTES,
Administrator.

Ravenswood Hospital,
Chicago.

The enclosure from the Ruby Hospital Building Fund Club, originated and sponsored by the Ruby Hospital of Ponca City, Okla., is in essence a chain letter, although its character is disguised somewhat by being called a "mutual benefit society." The Ruby Hospital, a sixteen-bed general hospital, is not registered by the American Medical Association.—Ed.

No Cash Deficit at Victory

At the close of its fiscal year the Victory Memorial Hospital, Waukegan, Ill., announced that it had no cash deficit although there is a bookkeeping deficit on items of depreciation of buildings and equipment. During 1933 and 1934, the ninety beds had an occupancy amounting to about 33 1/3 per cent while in 1935 the occupancy amounted to 40 per cent. The financial receipts for 1934 showed $52,203.44 with disbursements amounting to $50,830. For 1935 the estimated figures are $65,903.90 received and $65,019.12 disbursed.

LITERATURE *in* ABSTRACT • • •

Conducted by E. M. Bluestone, M.D.

Legal Authority in Medical and Surgical Practice

The author* presents a practical summation of the legal aspects of certain acts relating to medical practice, of interest to everyone engaged in serving the sick. What he has to say is of especial interest to hospital boards and administrators who may be called upon to hear the brunt of lawsuits based on factual or imaginary grounds.

Proper authority is required to perform a physical examination of a patient or to apply any form of therapy. Without proper authority the person performing such an act is guilty of "battery or a trespass" for which he may be tried and punished if adjudged guilty in a court of law.

The principles underlying proper authority for examination, operations and treatment, which the author describes, are generally applicable to all the states with modifications in some states established by statute or court decision. It is to be understood, however, that competent legal advice should be obtained where a doubt exists about a case before the act of examination is performed.

There are two basic principles underlying lawful authority (1) that arising out of a legal duty and (2) that relating to the consent of the patient or someone authorized to act in his behalf. The first concerns officers of the government acting under authority of existing laws which are valid and constitutional. The sterilization of patients in a state institution, performed by physicians acting under a eugenic sterilization law, is a good example of lawful authority arising out of a legal duty. The author cites many additional instances showing the application of this principle, all well worth reading.

In the general practice of medicine, valid consent as a rule constitutes lawful authority. Consent by a patient may, however, be invalid (1) if it deals with an unlawful act, or if it is contrary to public policy such as consent to a criminal abortion or operations for sexual sterilization, unless required to prevent or cure diseases or "antisocial tendencies," (2) if obtained from a person who has no right to grant consent, such as a minor child or a mental defective, and (3) if obtained by misrepresentation or fraud by claiming that an operation is necessary to save life when the case is not so.

Physicians should perform their services within the limits of the authority given to them. They may, however, secure authority granting the privilege of using their own judgment. If the consent is specific in its limitations and should conditions require a variation of the procedure, it is advisable, if the patient is under a general anesthetic or the influence of a narcotic, to have a person with full authority granted by the patient to act in his behalf, give the necessary authority to proceed in accordance with the recommendation of the physician. If the procedure is specifically limited and a representative of the patient is not available, the physician should do all that is necessary, in his judgment, for the safety of the patient.

An autopsy is defined as the "puncture or the cutting of a dead body for any purpose whatever." The discussion of consent for autopsies excludes the dissection of cadavers governed by "anatomic acts" in force throughout the country.

It is generally accepted that the right to grant or deny authority to perform an autopsy is vested in the next of legal kin, the surviving spouse. The courts are not agreed whether a person by will or agreement may authorize an autopsy on his dead body. If there is no wife or husband, the right is vested in the next legal kin, in order of relationship. A child of the deceased, under the latter circumstances, has prior rights over parents of the deceased. Parents are next in order of legal kinship, followed by brothers and sisters.

When death occurs under unusual circumstances, the custody and control of a dead body are vested in the medical examiner whose authority is supreme and who may perform an autopsy, within certain limits. A physician should never perform an autopsy on a body lawfully in the custody of a coroner or medical examiner without the consent of this officer and should not accept the consent of this official unless he is certain that consent is lawful.

Consent for autopsy may limit the degree of examination and if the limitations are not observed, the examiner may be liable for damages. Consent for autopsy does not confer the right to remove indiscriminately parts of the body for class instruction or museum specimens.

All forms of consent for operation and autopsy are valid whether implied by circumstances or granted orally or in writing. Consent should, however, be secured in writing, if possible, to eliminate all misunderstandings that may arise. A person lawfully in custody of a body, cooperating to bring about the performance of an autopsy, by his action approves the procedure and implies his consent. Misunderstandings may arise, however, if this procedure is followed. Oral consent, reenforced usually by implied consent, is common. Such consent may also be subject to misunderstanding but, if secured in the presence of disinterested witnesses, the chances of trouble are minimal.

The author suggests forms for consent to operation and autopsy and summarizes his presentation with specific instructions covering operation and autopsy. The entire article is replete with useful information that should be at the hand of everyone engaged in the practice of medicine, whether out in the community or in a hospital.

*Woodward, William C.: Authorization of Physical Examinations, Treatment, Operations and Autopsies, J. A. M. A., 106:33 (Jan. 4), 1936. Abstracted by Morris Hinenburg, M.D.

Protamine Insulate for Diabetics

Through work on insulin compounds which were not particularly successful and through investigations made for other purposes, these investigators[1] have discovered that protamine insulate, when used in the treatment of a diabetic patient, does not seem to have the same danger of underdosage and overdosage as insulin.

They have been working on this for more than two years. Eighty-five patients of all ages and with diabetes of varying degrees of severity were treated. Many blood sugar determinations were made each day.

When protamine insulate was used, the blood sugar curves were distinctly more level than when insulin was used. This would indicate that protamine insulate has a more prolonged effect from each injection than does insulin, and thus more nearly produces the effects of the regulated continuous secretion of the pancreas found in normal individuals.

The probable advantage of such a compound over insulin would be that larger doses could be administered and possibly severely ill patients could be kept sugar free without running the risk of producing a hypoglycemic reaction.

Presenting further clinical evidence on the use of protamine insulate is a group of American investigators.[2] In those cases where patients who are especially sensitive to insulin have been subject to large and sudden fluctuations in glycemia, the results of the use of protamine insulate have been to level off the peaks of the alternating periods of hyperglycemia and hy-

OWENS

ILLINOIS

& WARE

IMPORTANT TO HOSPITAL SUCCESS

● The prescription you give the patient leaving the hospital is often the only tangible representation of your institution that is taken into the home. It represents there for days or weeks the character of your hospital service.

If your prescriptions are packaged in the crisp, clean-cut, ethical-appearing containers made by Owens-Illinois they will register an impression of excellent condition and careful administration. They will build prestige for your hospital with both patient and doctor.

A liquid prescription put up in either an Owens or Illinois bottle, for example, cannot fail to command the patient's respect by the pleasing design, the clear, sparkling glass, the convenience of the neat molded cap and the security with which this perfectly fitting cap protects against spillage and contamination.

Owens-Illinois quality prescription ware—including the famous Emerald Green ointment jars, powder jars, dropper bottles and capsule and tablet containers—are produced with the same kind of care and skill that maintains in your laboratory. Accuracy of contents, strength and meticulous inspection prevent losses from breakage and leakage. Consequently these containers will prove to be of lowest net cost of any obtainable. All come to you electrically sterilized, capped, and ready for use. Your inquiry is invited.
Owens-Illinois Glass Company, Toledo, O.

OWENS-ILLINOIS

Complete Packaging Service

LOOK AT THE BOTTOM OF EVERY BOTTLE • MAKE SURE THE Onlzed TRADE MARK IS THERE

Onlzed

poglycemia. This reduces the dangers and discomforts encountered by many diabetics.

Here fifteen cases were studied and the explanation is made that presumably the slow break down of protamine insulate is in the subcutaneous tissues, and the blood sugar lowering action secured is more even and prolonged than that which follows an injection of insulin.

These clinicians emphasize that this preparation is definitely in the experimental stages as yet and more work will be necessary before it can be generally used. However, they present this as a bright outlook for the diabetic patient, for it may revolutionize the treatment of diabetes so that the patient may more closely resemble a normal individual.

[1]Hagedorn, H. C.; Jensen, B. Norman; Krarup, N. B., and Wodstrup, I.: Protamine Insulate, J. A. M. A. 106:177 (Jan. 18) 1936.
[2]Root, Howard F.; White, Priscilla; Marble, Alexander, and Stotz, Elmer H.: Clinical Experience with Protamine Insulate, J. A. M. A. 106:180 (Jan. 18) 1936. Abstracted by Anna E. Boller.

Reorganizing the Services at Westminster

The organization of British hospitals does not provide an integration of the junior medical services, rendered to out-patients, with the senior medical services to patients on the wards of the hospital. The surgeon or physician on service in the out-patient department does not have the opportunity to follow his patients to the wards. This division of service seems illogical to the author* and he is in favor of discontinuing it, unless the structural plans of the hospital buildings compel its preservation. He advocates a so-called "vertical division" of in and out-patients to replace the "horizontal division" and a plan to embody the change is now under consideration at the New Westminster Hospital.

Under this plan, there will be two full surgical units and accessory beds. Each unit will have a consulting room and theater so arranged that the unit on duty can readily make use of both without conflict. The out-patient rooms will be on the same floor adjacent to the wards, but reached by another entrance from a common corridor. Patients admitted to a unit will continue under the care of the same surgeons, nurses, registrar and house officers throughout their stay on the wards or their attendance in the out-patient service of the hospital. The physicians of the hospital will be grouped in a general medical department with a single out-patient department in which the various units will use the space according to a definite schedule.

A more complete service will be assured to patients without adding to the load of work carried by the honorary staff. It will also aid in solving the problem of out-patient waiting. Full-time officers, known as registrars, will be on duty in the emergency room and in "front surgery" to advise and supervise house officers, as well as to clear patients through to the proper units and select the teaching cases of the day.

The continuity of medical care and nursing service should benefit the patient and round out the training of the junior staff and of the nurses. The plan does not call for an increased nursing staff and it is unlikely that an increase will become necessary. The possibility of increased costs in general for the operating of scattered separate out-patient departments instead of a centrally organized department is not serious. Elevator service will cost more but economies will be possible through more efficient time saving services.

This plan carries the integration of in and out-patient service over from the field of organization into the field of construction, which is further than we have gone in America.

*Carling, E. Rock: A Modified Plan for a General Hospital: Changes Suggested at the New Westminster Hospital, Lancet 2:1314 (Dec. 7) 1935. Abstracted by Morris Hinenburg, M.D.

History of Three New York Ophthalmic Hospitals

Following are abstracts of brief historical sketches of the development of three special hospitals for the treatment of eye, ear, nose and throat diseases in New York City and Brooklyn. Until their establishment after the Civil War, the New York Eye and Ear Infirmary had been alone in serving the population of New York since 1820.

Brooklyn, with a population of 360,000 in 1868, did not have an eye hospital until a "company of gentlemen" considered it "expedient that an eye and ear infirmary be established."[1] A charter was obtained on May 2, 1868 and a building secured for the hospitalization of patients. One thousand eight hundred sixty-nine patients were treated during the first thirteen months at a total cost of $2,274, which included the expenses of furnishing the hospital and providing 1,025 days' board. Sixty-nine operations were performed. The first superintendent of the hospital was also the janitor for a few months.

After the first year, a building was purchased and the hospital entered a ten-year period of active and progressive developments. In 1874, 16,664 patients were treated; in 1877, 24,000 patients were treated at a total cost of $4,299. The new site soon proved to be inadequate and a new building was purchased for $47,000, $32,000 of which was subscribed by the members of the board of trustees.

In 1905 another building adjoining the hospital was added at a cost of $65,000, providing facilities for seventy ward beds and ten private beds. In 1905 and again in 1908 the nursing staff established an affiliation with St. Johns Hospital to improve nursing service. Money was voted for a nursing school.

In 1914 a building fund campaign for $1,500,000 to supplement the endowment fund was successful. The present hospital was opened on January 8, 1930. It is a modern institution of 180 beds equipped with all the requirements of modern eye, ear and throat work. In addition to the pathologic laboratory there is a research laboratory and a photographic department. In 1934, 48,449 new patients were treated. There are 120 on the medical staff, 14 interns, 60 nurses and 90 other employees. In 1868 the budget was $2,274; in 1934 it was $225,000.

Dr. Herman Knapp arrived in America from Germany in 1868, having surrendered a professorship in ophthalmology at Heidelberg. Shortly after his arrival he began the organization of a clinic[2] similar to the von Graefe Clinic in Berlin. The institution consisted of an out-patient department for the treatment of indigent patients by the chief surgeon and his staff, and a hospital division for the operative and hospital treatment of serious conditions. Patients in the hospital paid according to their means and the income from operations went to the surgeons. Plans for an aural department were also included. It was to be both a school and a laboratory and was therefore named the New York Ophthalmic and Aural Institute.

The institute, housed in a private home purchased and equipped by Doctor Knapp, opened on April 18, 1869. One thousand eight hundred twenty-eight patients were treated during the first year. Instruction was given to forty-six students. The charitable work of the hospital increased from year to year. Charges were brought before the New York Ophthalmological Society that "charitable institutions with accommodations for private patients may be made subservient to personal interests." As a result, the by-laws of the institute were revised to provide that all income for services to private patients be used for the support of the hospital.

In 1873 a laboratory for microscopic investigations of optic and acoustic conditions was organized. Additions to the hospital were made where necessary. Even though antiseptic surgery was still to come, 413 operations in one year were performed without

WHERE SUTURES ARE KEPT READY IN THE OPERATING ROOM

there's Safety in Everclear Alcohol!

AGAIN AND AGAIN during an operation, alcohol is called on to do an antiseptic job. Never is its dependability more necessary than when sutures are being kept ready for instant use.

However you use it, Everclear Alcohol does its work dependably and well. As an antiseptic, as a preservative, as a sterilizing medium, or as part of a prescription, you can have complete confidence in it. Conveniently located sources assure prompt delivery and dependable supply.

THE PURITY AND UNIFORMITY of the alcohol in which sutures are waiting are all important. You can always count on these properties in Everclear Alcohol.

EVERCLEAR ALCOHOL

The American Distilling Company

Selling Agents for AMERICAN COMMERCIAL ALCOHOL CORP.

405 Lexington Avenue · New York, N. Y.

the loss of an eye from suppuration. The institute continued its healthy growth and development until the volume of work, the medical research and the educational program resulted in the present Herman Knapp Memorial Eye Hospital. The new hospital was opened on October 1, 1913. In 1916 a dental clinic was established. The hospital continues as a pioneer in the study and treatment of eye and ear conditions.

A charter for the founding of the Manhattan Eye and Ear Hospital[3] was obtained on May 5, 1869, and the hospital was opened in December. The hospital was established to meet the needs of the poor for hospital care and its only income was derived from gifts and the payments for board that patients were able to make. Those who were unable to pay secured complete care without charge. Subsidies from the state and city treasuries were not requested. The hospital had no accommodations for private patients at the beginning. The medical officers in attendance served without salary.

The management of the hospital was directed by a group of twenty directors, medical and lay men. During the first fourteen months 1,717 patients were treated and 294 operations were performed. A laryngologic service was established in 1873. Clinical lectures formed an important part of the courses of instruction given to 364 physicians in 1873.

During the first ten years of service, the hospital treated 30,053 patients suffering from eye, ear, throat and nervous disorders, and a total of 4,912 operations were performed.

The hospital moved to new and larger quarters, with ward beds for seventy patients in 1881. There were also clinic facilities for treating eye, ear, nose and throat diseases as well as nervous diseases, rooms for refraction, a pharmacy and an optical department. Quarters were provided for a number of resident nurses and interns. No private patients were admitted. There were isolation rooms for difficult contagious eye cases and for cases requiring delicate surgical operations.

In 1888 private patients were admitted, but they were few at first. This was before the era of aseptic surgery and the statistics available for the period revealed fewer cases of septicemia and pyemia occurred amongst patients treated at home.

A pathologic laboratory, started for the examination of gross specimens and microscopic sections, was expanded to include the examinations of blood for malarial organisms, gonococci, micrococci, tubercle bacilli and Week's bacilli. In 1901 a technician was employed for the preparation of specimens.

In 1901, the hospital was again inadequate to meet the demands of the growing population. The number of patients increased from 1,717 in 1869 to 28,478 in 1903. A new site was purchased and a hospital erected which opened in 1906. The name was changed to the Manhattan Eye, Ear and Throat Hospital. The new hospital had 125 free beds, 35 private rooms and an x-ray department. A postgraduate school had been established earlier and the hospital continued to develop a fine educational program for nurses and doctors.

[1]Jameson, P. Chalmers: The Brooklyn Eye and Ear Hospital, 1868-1935, Arch. Ophth. 14:903 (Dec.) 1935.
[2]Knapp, Arnold: History of the Herman Knapp Memorial Eye Hospital, Arch. Ophth. 14:909 (Dec.) 1935.
[3]Wooton, Herbert Wright: History of the Manhattan Eye, Ear and Throat Hospital, Arch. Ophth. 14:914 (Dec.) 1935.
Abstracted by Morris Hinenburg, M.D.

Hospitals of Fraternal Organization

Fourteen years ago, the work of the Shriners' Hospitals* was started in Shreveport, La., with beds for fifty patients. The work has grown until there are now fifteen hospitals in the United States, Canada and Hawaii, with 850 beds. Twenty-five thousand children have benefited.

Crippled children, sensitive because of their physical disabilities, are educated to regain their self-esteem. They are encouraged to participate in games, to develop manual dexterity and to construct playthings and other useful articles.

In spite of reduced income, the high standards of service have been maintained in all these hospitals.

Each member of the organization is assessed two dollars annually for the maintenance of these hospitals. An effort will soon be made to establish a permanent fund by creating life memberships for sixty dollars, thereby relieving the members of annual assessments. The average cost of care for one child is $245.13. The annual cost of operating these hospitals is almost $900,000.

Hundreds of children are compelled to wait for admission. The hospital beds are occupied at all times and over 32,000 children have received care in the out-patient departments.

All funds for the hospitals are soundly invested and protected either by federal insurance or bonds.

The hospital units, owned outright or leased by the organization, are spaced throughout the country to meet the demands for service most effectively. All creeds, nationalities and races are admitted. Children must be under fourteen years of age, without mental abnormalities, and their parents must not be able to afford the cost of orthopedic care.

*Shriners' Hospitals for Crippled Children, The Meccan. 19: (Jan.) 1936. Abstracted by Morris Hinenburg, M.D.

Training Courses for Student Dietitians

The American Dietetic Association is now sponsoring two types of training courses* for student dietitians: nonhospital (administrative) and hospital (administrative and therapeutic).

The purpose of approved training for hospital dietitians is to provide trained college graduates, who are carefully selected on the basis of scholarship, ability, personality, health and character, with practice and instruction received in a dietary department.

The student takes responsibility under supervisors, who are preferably active members of the association, for a one-year period. Some hospitals are affiliated with colleges which grant credits for this work toward an advanced degree.

One-third of the practical experience should be in general administrative duties connected with food service for ward and private patients, staff and employees; one-third in diet therapy, including control of special diets and contacts with patients and one-third in infant and child feeding and teaching of student nurses, with some time allotted for clinic or social service nutritional work.

There are now 193 institutions contributing to the training of students. These approved hospitals with a description of the courses offered, their affiliations and locations are listed from the following: Canada, Connecticut, Colorado, District of Columbia, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Utah, Virginia and Washington.

The new type of education for nonhospital administrative dietitians makes it possible to train young women for controlling food standards in commercial restaurants and hotels and for directing food service in public school and college dining halls—in fact all public nonhospital institutions.

In October 1934, three such courses were approved by the inspection committees, with hope that more of these courses will be developed in other parts of the country. Massachusetts, Washington and Florida are the states having such courses and a description of such training is given.

The training of dietitians as directors of food clinics or as leaders of community nutrition education is an entirely new field, and it is hoped that during the ensuing year one or two centers may be developed for this type of training.

*Koehne, Martha: Training of Student Dietitians Approved by the American Dietetic Association, J. Am. Diet. A. 11:437 (Jan.) 1936. Abstracted by Judy Hoover.

SAFTIFLASK SERVICE

Dextrose and other solutions in SAFTIFLASKS are immediately available from exclusive distributors and Cutter branches located in major cities throughout the United States

The BLUE SAFETY SEAL found around the vacuum sealed closure of each Saftiflask is the *final precautionary step taken at Cutter Laboratories to assure the delivery of SAFE Dextrose and other solutions in Saftiflasks.

TAMPER PROOF . . . yet removed instantly with SAFETY to the operator and it works every time.

CUTTER *Laboratories*

Established 1897 **BERKELEY, CALIFORNIA**

111 North Canal Street, Chicago

New Orleans, La. Fort Worth and San Antonio, Tex.
Los Angeles, Calif. Seattle, Wash. Denver, Colo.

PRODUCERS OF VACCINES, ANTITOXINS AND OTHER ALLIED SPECIALTIES FOR THE MEDICAL PROFESSION SINCE 1897

EXCLUSIVE DISTRIBUTORS

The Burrows Company, Cleveland, Omaha and Chicago
Powers and Anderson, Norfolk and Richmond
Jones Apothecary, Louisville, Ky.
Surgical Selling Co., Atlanta, Ga.
Donley-Stahl Co., Lincoln, Neb.
The Hospital Import Company, Newark and Jersey City
The Hospital Import Corporation, New York
Surgeons and Physicians Supply Co., Boston
Physicians and Hospitals Supply Co., Inc.
Minneapolis, Minn.
Nashville Surgical Supply Co., Nashville, Tenn.
Physicians and Surgeons Supply Co., Spokane, Wash.
Southwestern Surgical Supply Co., Phoenix, Ariz.
Physicians and Hospital Supply Co., Portland, Ore.
Mid-West Surgical Supply Co., Inc., Wichita, Kans.
Brooks-Denhard Surgical Instrument Co., Louisville, Ky.
Birmingham Apothecary, Birmingham, Ala.
The Geo. Frye Co., Portland, Maine
Prescription Pharmacy, Salt Lake City, Utah

* The background of nearly forty years in the production and delicate testing of products for intravenous injection is your insurance against haphazard and perfunctory production and testing methods.

BOOKS ON REVIEW

NAMES OF SURGICAL OPERATIONS. *Compiled by the Committee on Names of Surgical Operations of the Western Surgical Association. St. Paul: Bruce Publishing Company,* 1935. *Pp.* xxi, 102. $3.

A TERMINOLOGY OF OPERATIONS OF THE UNIVERSITY OF CHICAGO CLINICS. *By Hilger Perry Jenkins, M.D. Chicago: University of Chicago Press,* 1935. *Pp.* 99. $1.

The first book is a distinct contribution to uniformity in medical records, the result of the painstaking work of a special committee of the Western Surgical Association, with the cooperation of numerous allied medical organizations to whom parts have been submitted for criticism. Its use should materially assist present efforts to "speak the same language" when reporting on surgical operations.

Six basic principles were adopted with the result that a large number of names of operations previously in use have been dropped. These principles are enumerated as follows:

1. Each operation shall have only one name.
2. Each name shall be in English (or a foreign language equivalent) and be philologically correct.
3. Each name shall be as simple and as short as possible.
4. The terms shall be merely memory signs and need lay no claim to description or speculative interpretation.
5. Related terms shall, as far as possible, be similar—*e.g.* Excision of the Knee Joint; Excision of Ulcer; Excision of Eye.
6. Personal names shall be avoided as far as possible.

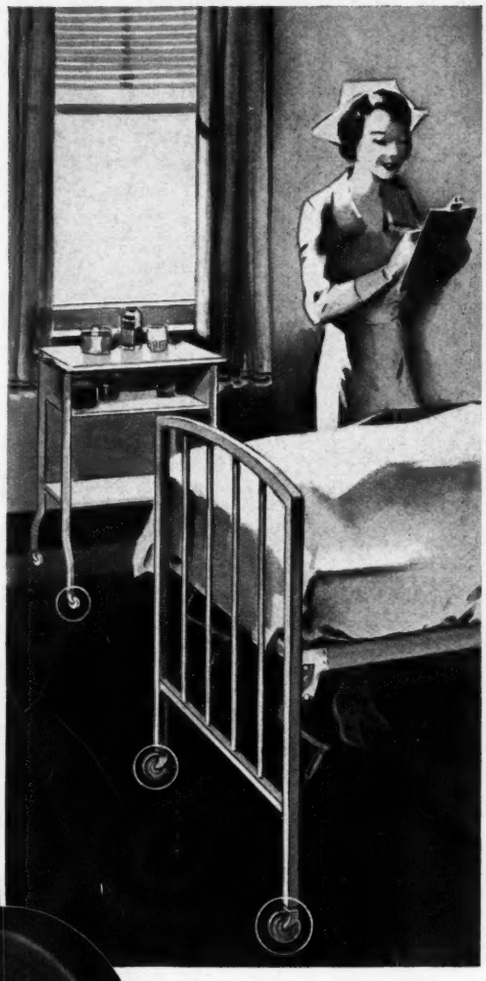
The book contains four appendices: (a) lists "Fundamental Surgical Procedures," using the common English terms; (b) lists "Philologic Suggestions and Corrections," probably interesting to the critic, but one which most surgeons and record librarians will skip; (c) lists "Suffixes," briefly but definitely for accuracy in designation, and (d) is an alphabetical index for easy reference.

The companion work prepared for the University of Chicago Clinics is a revision of a previous operation index plus the addition of omitted and differently worded operation terms which were taken from "Names of Surgical Operations" by the Western Surgical Association.

The purpose was to have a terminology that could easily be set up as an operation index file in the hospitals to lay the foundation for a more thorough statistical study of operations; a more adequate follow-up of end results and a more accurate showing of true mortality.

In this latter connection the author makes a pertinent suggestion which will appeal to all those responsible for the compilation of records. He states that most of our information on operative mortality is limited to two types of reports: one containing a series of cases done personally with a conspicuously low mortality and the other a review of a large series taken from records that frequently have a higher mortality. Between these two extremes lies the truth, but the profession can only guess at the average mortality.

This "Terminology of Operations," which is scarcely more than pocket size, contains 100 pages of rather small print and crowded material. Instructions are given for the record librarian to set up a filing cabinet and on the use of the index, which appear to be complete. Operations are listed according to systems—there is a chapter on obstetrical operations and one on radium therapy. Synonyms are given in connection with each operation where such exist.—GEORGE F. STEPHENS, M.D.



Caster illustrated is Style HR Double Ball Bearing Swivel Caster with "Spring Clip" solid steel socket. Furnished with rubber-tired wheel, Rubberex (cushion tread) Wheel or Rockite (hard tread) Wheel.

For every Hospital Need ~ ~

A SPECIAL CASTER

In designing casters for hospital use, Faultless has kept in mind the specialized requirements of this field. Hence every Faultless Hospital Caster meets the highest standards of easy, quiet movement, safety and durability. Yet, because of huge production, these fine casters are available at the price of ordinary equipment.

Send for the Faultless Hospital Caster Catalog—today! See the specialized designs—and how your every caster need can be satisfied from this one dependable source. Remember, too, that there is no obligation whatever in discussing your caster requirements with one of our representatives.

FAULTLESS CASTERS

FAULTLESS CASTER CORPORATION

Department MH-2, Evansville, Indiana

Branch Offices in Principal Cities
Canadian Factory: Stratford, Ontario

Reception room in Nurses Home, Meadowbrook Hospital, Hempstead, Long Island . . . with Sloane-made furniture.

ROOMS IN NEW HOSPITALS

as in private homes

ARE GRACIOUSLY APPOINTED

In planning today's hospitals, Sloane's Contract Department is often called in during the early stages. The wide scope of Sloane's services permits the rapid, economical completion of any furnishing or decorating project . . . from a single room to a whole building. And because Sloane's owns and operates its own furniture factories, Sloane-made furniture is not only well designed, but also stands wear and tear without costly repair. You are invited to consult Sloane's Contract Department without obligation, no matter how small your problem or how limited your budget.

FURNITURE OF STANDARD DESIGN, OR MANUFACTURED TO HOSPITAL SPECIFICATIONS • DRAPERIES • FLOOR COVERING • CUBICLES

CONTRACT DEPARTMENT

W&J SLOANE

575 FIFTH AVENUE • NEW YORK

NEW PRODUCTS • • •

Color—Furniture—Modern Design

"Royalchrome Tubular Steel" is the subject of this brief dissertation. Not that tubular metal furniture is strictly new (on strolling through a hospital some months ago, we noted the interns' suites furnished this modernistic way); but the makers of Royalchrome state the idea is still comparatively new to hospitals. And they declare that now that this modern sophisticated yet practical furniture has proved it can withstand the hardest commercial use, it is time to consider it for the hard wear and abuse in institutions.

Secure the complete story from Royal Metal Mfg. Co., 1138 South Michigan Avenue, Chicago—you will hear of such high lights as comfort, durability, brilliant luster of metal, variety in furniture design and application. And for those who are color conscious there is color diversity to suit, whether fancies turn to ebony black or to ultra blue.

Coffee at a Moment's Notice

A kind of Ripleyesque announcement, this. But that Master Cofi-lator introduced in January by Continental Coffee Co., Inc. (371 West Ontario Street, Chicago) is said to be an answer to the problem of producing fresh coffee at a moment's notice, with maximum economy and no waste. And fresh coffee, one reflects, is often just the right accent to a satisfying meal.

Dishwashing Its Way to Achievement

It's a commonplace, of course, when we refer to our present era as the machine age. Likewise, it's a truism when we state that manufacturers, dissatisfied with the machine age as it is, constantly create new and better machines.

A case in point is the new Colt Autosan dishwasher, Model RC-1. It is designed to do a big job, we understand, in a small space. Dishes are drawn through wash sprays at 4 feet per minute (moving slowly so that dishes may be thoroughly drenched) and through rinse sprays at 8 feet per minute (speeding up to save time as well as hot water). However, racks can be stopped for extra washing or rinsing, or, by loosening a screw, trays can be pushed through manually.

For other details, new automatic features for instance, we suggest your writing Colt's Patent Fire Arms Mfg. Co., Hartford, Conn.

Baby Gets a Break

All the desirable characteristics of a surgical dressing are claimed for the new Curity Layettecloth diaper—a product of the Lewis Mfg. Co., Walpole, Mass. The light, airy open weave of this nondisposable type diaper allows a free circulation of air, very soothing to a baby's tender epidermis. Yet, we are told, the new fabric is satisfactorily absorbent. As an additonal comfort the diaper is made of two layers of cloth, woven together with one smooth selvage, so there are no hems to make irritating ridges.

WHITE KNIGHT HOSPITAL GARMENTS

Comfort and long wear are notable features in all White Knight Garments. Materials specially chosen, cut full and roomy and sewed throughout with lockstitching. Prices are low.

Upper Left — Operating Gown — F-20. An outstanding value. Great comfort and wear. Unbleached Sheeting, W. R. Special Cloth, White Knight Twill — a remarkable quality — and Genuine Indian Head.

Lower Left — Patients' Gown — F-10. One of our leaders. Will stand repeated laundering and hard wear. Unusually comfortable. Unbleached Sheeting, W. R. Special Cloth, White Knight Twill.

Center — Professional Uniform — F-532. Excellent example of White Knight Style. Under arm shields. Side opens with snaps. Burton's Irish Poplin or White Knight Poplin, both Sanforized Shrunk.

Upper Right—Nurses' Operating Gown—F-40. Another leader. Cut roomy for freedom and comfort, yet attractive. 51 inch length. W. R. Special Cloth, White Knight Twill, Genuine Indian Head.

Lower Right — Operating Suit — F-122. Trim, good looking; serviceable and comfortable. A good value. Kenwood Cloth, White Knight Twill, W R. Special Cloth.

ROSS, Inc.

Wholesale Hospital Supplies, Milwaukee, Wisconsin

White Knight
MILL. ROSS, INC. MILWAUKEE, WIS.
GARMENTS

Three Steps to Developer and Fixer

Pour—add water—stir. In other words, all you need do to make F-R X-ray developer or fixer is to pour the contents of the bottle into the tank, add cold water and stir. In less than a minute, states Fink-Roselieve Co., 109 West Sixty-fourth Street, New York, you have made a pure, noncaustic, odorless developer for producing films of brilliance and fine definition; or you have made an F-R fixer that "fixes" films cleanly and quickly. It is indicated, too, that these liquids are stable in both concentrated and dilute form.

A Lighter and Completely Redesigned Breast Pump

This fragment of news concerns a breast pump, significantly "new and improved." They call it "Perfection" but we would nickname it "Convenience." Necessity, you see, invented it in the first place. Then convenience came along, insisting on reducing nurses' burdens and promoting the mother's comfort. For Perfection Mfg. Corp. has created a lighter machine, easier to carry about. Further transforming a nurse's job, there's ease of cleaning (no exposed moving parts), and construction so simple that a patient can operate it herself. Moreover, it's a boon to mothers—its use is not an ordeal. Action is gentle and a quietness of operation prevents that "case of nerves." Besides outlining the above improvements in the machine, this Minneapolis company summarizes on an illustrated sheet the essential uses of an electric breast pump. It's worth careful reading.

Masks on Parade

We refer not to costumes for holiday parties but to a new mask for operating and maternity rooms, nurseries or contagious wards. "Plastacele," it's called, and the Du Pont Viscoloid Company claims for it advantages four-fold: it permits clear voice transmission; it's impermeable to bacteria; it may be cleaned and sterilized easily, and it's comfortable and safer because there is no steaming of one's glasses.

Oil on Troubled Skin

Out in Dubuque, an Iowa city that grew up on the shore of the Mississippi, there's a company entirely familiar with turbulent waters. Comes a sheet from Midland Chemical Laboratories, Inc, with this opening paragraph: "Just as oil spread upon turbulent water brings it to a state of quietude, so does a bland antiseptic oil have that soothing effect upon babies." And on this sheet, a field chemist for Midland outlines what a baby oil should be: nonirritant; nontoxic; so compounded that it does not become rancid; of the quality that it immunizes skin to bacterial infection; germicidal; penetrative; of waterproofing quality to guard against irritations; finally, it must not stain linens, be guilty of "gumminess" or leave greasy residue.

Pacometer and Boiler Salines

It's been said that names come cheaper by the yard. We offer as a special bargain in nomenclature the "Pacometer (Permutit Automatic Compensating Hydrometer)." This, announces The Permutit Co., 330 West Forty-second St., New York, is a new hydrometer for measurement and control of boiler salines.

"With the increasing requirement for lower operating concentrations in modern boilers," they explain, "there has

come an increased demand for a compensating instrument that would indicate the concentration with greater accuracy and, at the same time, would retain the desirable features of speed and simplicity and, if possible, possess greater strength than former all-glass instruments. We have finally produced an instrument that meets these requirements.

"The Pacometer is calibrated for quick reading at either high or low temperature ranges and has a self-contained thermometric correction scale in the bulb, which scale shows directly the density correction in the same concentration units as the stem itself."

Paging New Literature!

All-Star Foursome on Lighting and Other Castle Products—"Not looking for trouble but ready for it" seems the slogan of the house of Castle. Sterilizer replacements, for instance. A new booklet gives details and costs for replacement of worn-out sterilizers in the surgery. Then, there's the matter of ruined instruments and gloves—damage possibly chalked up to the sterilizer. Another new booklet suggests that with a Castle "Full-Automatic" the nurse can put articles in the sterilizer and safely forget them.

A third booklet, with cleanliness of bedpans as its theme, describes modern apparatus for cleaning and sterilizing bedpans and urinals. But you are interested in modern surgical lighting? Then Wilmot Castle Co., Rochester, N. Y., will send you a brochure showing new developments in major lighting equipment—among these an amphitheater model which will not obstruct the view of spectators. The booklet also shows auxiliary spotlights for supplementing antiquated overhead lighting.

Five Hundred Pages of Instruments and—Climaxing twenty-three former editions of K-S catalogues is the twenty-fourth, recently published by Kny-Scheerer Corp., Long Island City, N. Y., a company proud of its forty-seven years' service to the medical and hospital field. It is no digest, this new volume, but a thoroughgoing portrayal of instruments from the general to the diagnostic. K-S hospital equipment and supplies join the instrument parade, with such items featured as operating tables and clinical furniture. Of interest, too, is a page on the sterilization and care of surgical instruments.

No Painted Snakes on These Floor Coverings—An Old Chinese proverb explains that "exaggeration is to paint a snake and add legs." You'll think we exaggerate when we report that a small new booklet from Congoleum-Nairn, Inc., Kearny, N. J., offers fifty pages of different patterns and divers colors in Adhesive Sealex Linoleum and Treadlite Inlaid. We are informed that these linoleums are laid quickly (because of factory-applied adhesive on the back), are soon ready for use, are inexpensively installed, may be laid directly over wood or concrete floors and require no paste or felt lining. The new Treadlite also features a very smooth, easy-to-clean surface of inlaid durability (color through to the backing).

Banishing Boiler Breakage—To inexperienced eyes a low pressure heating boiler may look big enough to take care of itself, but, we are reliably informed, without proper protection it is subject to breakdowns—even as you and I. Many breakdowns of low pressure boilers are due to low water. Warren Webster & Co., Camden, N. J., offers a boiler protector which automatically maintains the desired level and also acts as a danger indicator. The facts about boiler breakage and its prevention are discussed in a brochure (published Anno Domini 1935) complete with diagrams easily understood.